HENNEPIN HEALTH

Minnesota Health Care Programs (MHCP)

MA Home Care Technical Change Request

Complete and fax this form to 612-677-6222 to request a technical change to an existing approved home care (non-PCA) service authorization for your agency.

Request Type (select one) Change/Start Date __/__/____ End Date __/__/____

☐ Provider Change (select one):
- ☐ New provider
- ☐ Cancel SA
- ☐ Decrease

☐ Adjust PDN units (when no increase)

☐ Other (Use Treatment Plan/Additional Information to explain)
- ☐ Recipient change (MHCP ID, name, etc.)
- ☐ Duplicate copy of SA ___________

Recipient Information

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

Services

Type of service	Total for dates requested	Start/Change date	End date
☐ T1030 SKILLED NURSE (SNV)	________ (LIMITED TO 2 PER DAY)	__/__/____	__/__/____
☐ T1030 GT TELEHOMECARE (SNV)	________ (LIMITED TO 2 PER DAY)	__/__/____	__/__/____
☐ T1021 HOME HEALTH AIDE (HHA)	________ (LIMITED TO 1 PER DAY)	__/__/____	__/__/____
LPN: ☐ T1003 – LPN REGULAR	________	__/__/____	__/__/____
☐ T1003 – TG LPN COMPLEX	________	__/__/____	__/__/____
☐ T1003 – TT LPN SHARED	________	__/__/____	__/__/____
RN: ☐ T1002 – RN REGULAR	________	__/__/____	__/__/____
☐ T1002 – TG RN COMPLEX	________	__/__/____	__/__/____
☐ T1002 – TT RN SHARED	________	__/__/____	__/__/____

Provider Agency Information

PROVIDER NAME		PROVIDER NPI/UMPI
		___________
NAME/TITLE OF REQUESTOR	PHONE NUMBER	FAX NUMBER

Additional Information/Treatment Plan

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
	__ / / __ __ __

MA Home Care Technical Change Request

Purpose of Home Care Technical Change Request

To request technical changes and corrections to existing SAs for:

- Skilled Nurse (SN)
- Home Health Aide (HHA)
- Private Duty Nursing (PDN)

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

Check one box to indicate the type of request. 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)
- Enter the date of birth

Services

- Check appropriate box to indicate the requested service(s)
- For each service you request:
  - Enter the total number of visits. (Note: DHS is not able to authorize more than two SN visits or more than one HHA visit per day)
  - Enter the start of service/change date
  - Enter the end of service date

Provider Agency Information

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

Additional Information/Treatment Plan

Enter additional information regarding the request or treatment plan.

Recipient/Responsible Party Signatures

Required when “New Provider” request type.

Hennepin Health 612-596-1036

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.

LB3-0001 (3-13)

This information is available in other forms to people with disabilities by calling 1-800-647-0550 (toll free), or 1-800-627-3529 (TTY), or 711, or through the Minnesota Relay direct access numbers at 1-800-627-3529 (TTY, Voice, ASCII, hearing carry over) or 1-877-627-3848 (speech-to-speech).

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For enrollees age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.