Provider Change Attestation Form

For Medicaid recipients who have appealed an adverse decision, or whose provider agency is going out of business, or are changing providers for another service with an authorization period of six months or more, the current authorization for services will transfer to the new provider within five (5) business days of notification by the new provider to the appropriate utilization review vendor and upon submission of written attestation. Attach completed form for MH/SA services via the Send Inquiry function located on the Member Demographics screen in ProviderConnect.

Recipient Name: _____ Medicaid ID Number: _____

Previous Provider: _____ Medicaid Provider Number: _____

New Provider: _____ Medicaid Provider Number: _____

Level of Care: _____

Note: This change will be at the current level authorized, take effect on the date received by the UR vendor and end on the date of the existing authorization on file for the previous provider. Any requests of additional units/days or future reauthorization requests will not be processed with this form and are subject to a medical necessity review.

By signing below our agency attests to the following;

- Provision of the service requested meets Medicaid policy
- The recipient's condition meets coverage policy
- Our agency accepts all associated responsibility for provision of the service

AND has obtained either;

- Written permission of recipient or legal guardian for transfer

  OR

- A copy of the discharge from the previous provider

_____ _____

Responsible Party Date