Louisiana Department of Health and Hospitals
Medicaid Program
Notice of Medical Certification

Print Form

Date

Refer to the 1915(c) waiver, the 1915 (b) waiver, the 1915 (i) state plan amendment, and the DHH policy on the submission of the Medicaid 142 BH, for applicable details. Fax To: Louisiana Medicaid, Central Processing Center, Fax 1-318-487-5983

I. Demographic Information

☐ Update Personal Information Effective Date

Recipient Name SSN Date of Birth

Home Address Parish

Is the recipient enrolled in Medicaid? ☐ Yes ☐ No

Medicaid number, if already assigned, or date referred to a Medicaid Application Center

II. Coordinated System of Care

If applicant is under the age of 18, provide the following information of the responsible party:

Name SSN (optional)

Date the Freedom of Choice was signed

Current Living Setting, CANS Level, and Waiver Proposal

Living Setting

CANS Level

Waiver Proposal

III. 1915 (i) State Plan Amendment

For adults age 21 and older or 19 and older if not otherwise eligible for Medicaid, indicate by checking the box below if he/she is eligible for the 1915 (i) SPA

☐ 1915 (i) SPA

IV. Disenrollment

☐ Check this box if the recipient is no longer enrolled in the 1915 (c) waiver, 1915 (b) waiver, or the 1915 (i) SPA

Disenrollment Date

V. Proposed Effective Date Range

Waiver Proposal Begin Date Waiver Proposal End Date