Choice of Provider Form
for EPSDT Medicaid Providers

This form should be used for all Medicaid services requiring prior authorization

Type of Service (*Check the following service(s) that applies.)*

☐ **Physical Therapy**	☐ **Behavioral Health Services**
☐ **Occupational Therapy**	☐ **Dental Services**
☐ **Speech Therapy**	☐ **Vision Services**
☐ **Audiology Services**	☐ **Extended Home Health**
☐ **Medical Equipment (DME)**	☐ **Nutritional Services**
☐ **Medical Supplies**	☐ **Applied Behavioral Analysis (ABA)**
☐ **Personal Care Services**	☐ **Other**_____

The beneficiary/family must check the appropriate statement below.

☐ **My support coordinator has explained to me that I have a choice of service providers when there is a choice available. I have reviewed a list of available providers and I understand that this list may not include <u>every</u> available provider. I understand that I may choose a new provider at any time. I have selected the following provider(s).** *(Beneficiary/family may choose to list 1st, 2nd, 3rd choice.)*

1._____

2._____

3._____

☐ **My support coordinator has explained to me that I have a choice of service providers when there is a choice available. I have been informed that there is only one (1) provider available for this service. I understand that I may choose a new provider at any time if another provider is available. I have requested that a referral be made to this provider.** *(List provider.)*

1._____

☐ **I have already chosen the provider that I want. I do not wish to review a list of available providers. I understand that I may choose a new provider at any time. I have requested that a referral be made to this provider.** *(List provider.)*

1._____

Beneficiary/Authorized Representative must sign and date below.

_____ _____

Beneficiary/Authorized Representative *Date*

_____

Relationship to Beneficiary