

EPSDT – Targeted Population – Choice of Provider Form

This form must be used for all requested Medicaid services that require prior authorization.

<b>Beneficiary Name:</b>	
<b>Type of Service Requested:</b>	
<input type="checkbox"/> <i>EPSDT-Personal Care Services</i>	<input type="checkbox"/> <i>Medical Equipment &amp; Supplies</i>
<input type="checkbox"/> <i>Home Health Services</i>	<input type="checkbox"/> <i>Specialized Behavioral Health</i>
<input type="checkbox"/> <i>Pediatric Day Healthcare</i>	<input type="checkbox"/> <i>Applied Behavioral Analysis (ABA)</i>
<input type="checkbox"/> <i>Therapy Services (ST, OT, PT, Audiology)</i>	<input type="checkbox"/> <i>Other: _____</i>
<b>The beneficiary/legal guardian must check the appropriate statement and sign below:</b>	
<input type="checkbox"/>	<p><b>1. My SC explained that I have a choice of service providers when there is a choice available.</b> I have reviewed a list of available providers. 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). I have requested that a referral be made to this provider. If my first choice of provider is not available, please make a referral to my next choice(s):</p> <p>1<sup>st</sup> Choice of Provider: _____</p> <p>2<sup>nd</sup> Choice of Provider: _____</p> <p>3<sup>rd</sup> Choice of Provider: _____</p>
<input type="checkbox"/>	<p><b>2. My SC has explained to me that I have a choice of service providers when there is a choice available.</b> I have been informed that <b>there is only one (1) provider available for this service.</b> 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:</p> <p>Choice of Provider: _____</p>
<input type="checkbox"/>	<p><b>3. I have already chosen the provider that I want.</b> 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:</p> <p>Choice of Provider: _____</p>

\_\_\_\_\_  
**Beneficiary/Guardian Signature and Relationship**

\_\_\_\_\_  
**Date**

The SC may obtain a verbal Choice of Provider if needed for a timely referral to the provider. The family must have a list of providers or know who they want. The SC may not give a partial list of providers to the family to choose from. The SC must complete this form documenting the beneficiary’s choice of provider, make a referral to the provider and mail a copy of the verbal COP to the beneficiary.

I certify the beneficiary/guardian selected the above choice of provider.

\_\_\_\_\_  
**SC Signature**

\_\_\_\_\_  
**Date**