EPSDT - Targeted Population - Referral to Provider

Date	
To: Provider Agency	
Beneficiary's Name	
Beneficiary's DOB	
Beneficiary's Medicaid ID #	
Beneficiary's Insurance	☐ Aetna Better Health ☐ AmeriHealth Caritas ☐ Healthy Blue ☐ Humana Healthy Horizons ☐ Louisiana Healthcare Connections ☐ Fee-for-Service Medicaid
Responsible Party	
Beneficiary's Telephone #	
Beneficiary's Address	
Support Coordination Agency	
Support Coordinator's Name	
Support Coordinator's Phone #	
Support Coordinator's Fax #	
Support Coordinator's E-mail	
Type of Service Requested	
Type of Request	☐ Initial ☐ Renewal, previous PA end date: _____
Amount of Requested Service	

This is to inform you that this beneficiary is receiving EPSDT Support Coordination Services and we are sending this notice to:

☐	**1. Make a Referral** - Please **send us a copy of the PA request packet** at the same time it is sent to the Fiscal Intermediary (Gainwell Technologies for FFS) or the MCO.
☐	**2. Schedule Issues** – The beneficiary has asked that their schedule for your services be changed as per the attached Typical Weekly Schedule form. If this presents a problem, please contact the Support Coordinator listed above so that we can discuss this with the beneficiary/family. ☐ Typical Weekly Schedule attached
☐	**3. Renewal Reminder** - This is a reminder that the PA ends on: _____. Please **send us a copy of the PA request packet** at the same time that it is sent to the Fiscal Intermediary (Gainwell Technologies for FFS) or the MCO.
☐	**4. Other –**

_____I certify that I have completed this form in its entirety and I have checked for misspellings.

SC Signature and Date: _____