

**EPSDT - Targeted Population - Referral to PAL**

<b>Date</b>	
<p><b>To: CHECK ONE</b> *Check MEVS and then send to the appropriate PAL. MCO = goes to MCO PAL. FFS = goes to LDH PAL.</p> <p><input type="checkbox"/> Aetna Better Health: Fax 844-634-1109 or <a href="mailto:ChisholmReferrals@aetna.com">ChisholmReferrals@aetna.com</a></p> <p><input type="checkbox"/> AmeriHealth Caritas: Fax 866-397-4522 or <a href="mailto:aclacompliance@amerihealthcaritasla.com">aclacompliance@amerihealthcaritasla.com</a></p> <p><input type="checkbox"/> Healthy Blue: Fax 844-839-9307 or <a href="mailto:LA1-Chisholm@healthyblue.com">LA1-Chisholm@healthyblue.com</a></p> <p><input type="checkbox"/> Humana Healthy Horizons: Fax 833-797-0293 or <a href="mailto:LAMCDChisholmPALiaison@humana.com">LAMCDChisholmPALiaison@humana.com</a></p> <p><input type="checkbox"/> Louisiana Healthcare Connections: Fax 877-668-2079 or <a href="mailto:BRO_LHCC_Chisholm@louisianahealthconnect.com">BRO_LHCC_Chisholm@louisianahealthconnect.com</a></p> <p><b>OR</b></p> <p><input type="checkbox"/> Fee-for-Service Medicaid ONLY - LDH PAL Danielle Boykin: Fax 225-389-2749</p>	
<b>Beneficiary's Name</b>	
Beneficiary's DOB	
Beneficiary's Medicaid ID #	
Responsible Party	
Beneficiary's Telephone #	
<b>Provider's Name</b>	
Provider's Medicaid ID #	
Provider's Telephone #	
Provider's Office - Contact Person Name	
<b>Support Coordination Agency</b>	
Support Coordinator's Name	
Support Coordinator's Telephone #	
Support Coordinator's Fax #	
Support Coordinator's E-mail	
<b>Type of Service Requested that requires Prior Authorization</b>	
PA Status - Be specific!	
Type of Request	<input type="checkbox"/> Initial <input type="checkbox"/> Change in Service <input type="checkbox"/> Renewal, previous PA expires(d) on: _____
Amount of Requested Service	
Date of Choice of Provider (COP)	
Date(s) of Referral to Provider	

**This beneficiary is receiving EPSDT Support Coordination Services and we are having/had the following problem:**

<input type="checkbox"/>	<b>1. Untimely PA Packet Submission (35 Day PAL)</b> - Provider has not submitted the PA packet within 35 calendar days of the date of Referral to Provider.
<input type="checkbox"/>	<b>2. Untimely PA Notice (60 Day PAL)</b> - We have not received a PA decision within 60 calendar days of the date of Choice of Provider.
<input type="checkbox"/>	<b>3. Renewal PA not received</b> - We have not received a notice of approval for the Renewal and the previous PA expired.
<input type="checkbox"/>	<b>4. Unable to locate provider</b> - The beneficiary has been unable to locate a provider that is willing to submit a request for a prior authorization. <input type="checkbox"/> Managed Care ONLY: Date SC contacted MCO's Member Services Line: _____ <i>Fee-for-Service ONLY: Date SC contacted the LDH Program Staff Line: _____</i>  <input type="checkbox"/> I have <b>attached</b> a list of providers I have contacted that have refused to submit a request for PA.
<input type="checkbox"/>	<b>5. Waitlist Placement</b> - The beneficiary was placed on a waitlist. <u><b>CHECK ONE</b></u> <input type="checkbox"/> The family was offered alternative providers and wants to continue to wait for this provider to have availability. <input type="checkbox"/> The family was offered alternative providers and wants to look for alternative providers. Please assist. ----- <u><b>CHECK ONE</b></u> <input type="checkbox"/> I have <b>confirmed</b> waitlist placement with the provider. I will follow up with the provider at least monthly to assure they move up the waitlist. <input type="checkbox"/> I have been <b>unable</b> to confirm waitlist placement with the provider. Please assist. ----- <u><b>ANSWER BOTH</b></u> <input type="checkbox"/> Date placed on waitlist: <input type="checkbox"/> Estimated wait time:
<input type="checkbox"/>	<b>6. Schedule Issues</b> - The provider is not providing services at the times the beneficiary requested. <input type="checkbox"/> Schedule requested: <input type="checkbox"/> Schedule being provided:
<input type="checkbox"/>	<b>7. Amount of Service Issues</b> - The provider is not providing the amount of services as prior authorized. <input type="checkbox"/> Hours Authorized: <input type="checkbox"/> Hours being provided:
<input type="checkbox"/>	<b>8. Other</b> -

**For Managed Care Services ONLY: If the MCO is unable to resolve the issue within 10 working days of the Referral to PAL, the MCO will alert the Chisholm Compliance Team. The alert will include the actions the MCO has taken and the reasons why the member's services are not in place.**

\_\_\_\_\_ I certify that I have completed this form in its entirety and I have checked for misspellings.  
 \_\_\_\_\_ I certify that I have **attached** the EPSDT Prior Authorization Tracking Log(s), all Referrals, e-mails and supporting Service Logs that document the contacts made regarding the issues identified above to this form.

**SC Signature and Date:** \_\_\_\_\_