

Idaho Medicaid Enhanced Plan Request Form - IDHW H0002

Directions: Please fill in all blanks, print and sign the form, submit to the Idaho Falls Processing Center by fax at 208-528-5933 or 888-532-0014. You may choose to submit the form electronically to: HCCR7@dhw.idaho.gov
Maintain original in participant's record.

IDENTIFYING INFORMATION

Name of Participant: _____ Medicaid ID#: _____

Printed Name of Agency and Agency Medicaid Provider #: _____

Name of Provider Certifying Medicaid Enhanced Plan: _____
(Please print)

Agency Phone # _____ Agency Fax # _____

RATIONALE FOR ENHANCED PLAN SERVICES

(Provider: please check the appropriate box as indication of the justification for this participant needing the Medicaid Enhanced Plan)

Participant needs the following services:

- | | |
|--|--|
| <input type="checkbox"/> Additional Psychotherapy | <input type="checkbox"/> Service Coordination |
| <input type="checkbox"/> Partial Care | <input type="checkbox"/> Developmental Disabilities |
| <input type="checkbox"/> Psychosocial Rehabilitation | <input type="checkbox"/> Inpatient Psychiatric Hospitalization |

CERTIFICATION

I have assessed _____ on _____ and certify that this
(Name of participant) (date)
participant meets the requirements in IDAPA 16.03.10 for receiving the above indicated services
in the Medicaid Enhanced Plan. Please start enhanced services effective _____.

Signature of Provider Certifying Participant's Eligibility

Date

Please contact 1-888-528-5861 for additional information