

N.C. Department of Health and Human Services – Division of Medical Assistance
IN-HOME CARE SERVICES (IHC)
CHANGE OF PROVIDER REQUEST

Complete this form and send to The Carolinas Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail:
CCME, ATTN: IHC Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598.
For questions, contact CCME at 800-228-3365 or IHCAssessment@thecarolinascenter.org.

Requested By: ___ PCP ___ Attending MD ___ Recipient ___ Recipient's Responsible Party

Date of Request: ___/___/___ (mm/dd/yyyy)

Section A. Recipient Demographics

Medicaid ID#: _____

Recipient Name (as shown on Medicaid Card) First: _____ MI: ___ Last: _____

Date of Birth: ___/___/___ (mm/dd/yyyy) **Gender:** ___ Male ___ Female **Primary Language:** ___ English ___ Spanish ___ Other

Address: _____ **City:** _____

County: _____ **State:** ___ **Zip:** _____ **Phone:** (____) _____ - _____

Alternate Contact/Parent/Guardian (required if recipient under 18): First: _____ Last: _____

Relationship to Recipient: _____ **Phone:** (____) _____ - _____

Section B. Provider Information

Reason for Provider Change:

- Recipient choice
 Current agency unable to continuing providing services
 Other: _____

Status of IHC Services:

- Discharged on ___/___/___ (mm/dd/yyyy)
 Scheduled for discharge on ___/___/___ (mm/dd/yyyy)
 Continue receiving services until established with a new provider agency; no discharge planned at this time

Recipient's Preferred Provider (if known):

Agency Name: _____

Location: _____

Phone: (____) _____ - _____

Agency Name (Alternate): _____

Location: _____

Phone: (____) _____ - _____

Section C. Contact Information for Questions about Change of Provider Request (if not Recipient or Alternate Contact listed in Section A):

Contact Name: _____ **Relationship to Recipient:** _____

Phone: (____) _____ - _____ **Fax:** (____) _____ - _____ **E-mail:** _____