

**N.C. Department of Health and Human Services – Division of Medical Assistance
REQUEST FOR INDEPENDENT ASSESSMENT FOR PERSONAL CARE SERVICES
CHANGE OF PROVIDER – INSTRUCTIONS**

Indicate whether requesting entity is recipient's primary physician (may include PA or NP), attending physician/hospitalist of inpatient facility, the recipient or recipient/responsible party

Section A – Recipient Demographics

- Complete all information related to recipient demographics. Please include name and telephone number of alternate contact in case we have difficulty reaching recipient if there are questions related to this change of provider request.

Section B – Provider Information

- Indicate the reason for the provider change. If reason is not one of the choices listed, please describe in 'Other' field.
- Indicate if you have been or anticipate being discharged from the provider and the date of discharge.
- List information about your preferred provider. If you do not know what provider agency you would like to receive services from, CCME will assist you in selecting a provider.

Section C – Contact Information for Questions about Change of Provider Request

- Complete contact information if person requesting the provider change is not the recipient.

**Completed referrals should be printed and faxed to CCME at 877-272-1942 or mailed to:
CCME
ATTN PCS Independent Assessment
100 Regency Forest Drive, Suite 200
Cary, NC 27518-8598**