

# Children's Home and Community Based Service Notification



It is the responsibility of the Children's Home and Community Based Service (CHCBS) provider to notify MVP Health Care® of the first scheduled CHCBS appointment with the child/family/youth. Notification to MVP regarding the first CHCBS appointment must be made immediately. If the appointment changes, the CHCBS provider will notify MVP of the new appointment prior to the new date. The CHCBS provider should not wait until they have exhausted the initial service amount of 60 days, 96 units or 24 hours. Upon receipt of notification of the first appointment, MVP will ensure payment for the initial 60 days, 96 units or 24 hours of treatment.

**Submit this completed request to MVP by email to [communityservices@mvphealthcare.com](mailto:communityservices@mvphealthcare.com) or fax to 1-855-853-4850.**

## Section 1: Patient/Member Information

(\*Required)

Patient/Member Name *	Date of Birth *	MVP Member ID No. *	Phone No. *
Street Address *		City *	State * Zip Code *

## Section 2: Requesting CHCBS Provider Information

(\*Required)

Referent Name	Referral Practice/Agency Name
Street Address	City State Zip Code
Phone No.	Fax No. Email Address

Requesting HCBS Provider Name	Provider Contact Name *
Street Address	City State Zip Code
Phone No. *	Fax No. * NPI No. Tax ID No. MMIS No.
Email Address	

## Section 3: CHCBS Service Information

Select all CHCBS service(s) being requested and provide the first CHCBS appointment date for each service selected.

- |   |  |
|---|--|
| <input type="checkbox"/> Community Habilitation<br><i>First Appointment Date:</i> _____ | <input type="checkbox"/> Caregiver/Family Advocacy & Support Services<br><i>First Appointment Date:</i> _____  |
| <input type="checkbox"/> Day Habilitation<br><i>First Appointment Date:</i> _____       | <input type="checkbox"/> Palliative Care Pain & Symptom Management<br><i>First Appointment Date:</i> _____     |
| <input type="checkbox"/> Respite<br><i>First Appointment Date:</i> _____                | <input type="checkbox"/> Palliative Care Massage Therapy<br><i>First Appointment Date:</i> _____               |
| <input type="checkbox"/> Prevocational Services<br><i>First Appointment Date:</i> _____ | <input type="checkbox"/> Palliative Care Expressive Therapy<br><i>First Appointment Date:</i> _____            |
| <input type="checkbox"/> Supported Employment<br><i>First Appointment Date:</i> _____   | <input type="checkbox"/> Palliative Care Counseling & Support Services<br><i>First Appointment Date:</i> _____ |

*Patient/Member Name*

*MVP Member ID No.*

**Section 3: CHCBS Service Information** *continued from page 1.*

**Desired Goal or "Need" to be addressed:**