

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 bhservices@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)

Requestor Name *	Practice Name *	
Street Address *		
Phone No. *	Fax No.	Email Address *

Primary Contact Name	<input type="checkbox"/> Same as Requestor	Phone No.	Fax No.
Street Address		City	State Zip Code
Email Address			

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

Section 3: CHCBS Service Information (*Required)

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

- | | |
|--|---|
| <input type="checkbox"/> Community Habilitation
<i>First Appointment Date:</i> _____ | <input type="checkbox"/> Prevocational Services
<i>First Appointment Date:</i> _____ |
| <input type="checkbox"/> Day Habilitation
<i>First Appointment Date:</i> _____ | <input type="checkbox"/> Supported Employment
<i>First Appointment Date:</i> _____ |
| <input type="checkbox"/> Respite
<i>First Appointment Date:</i> _____ | <input type="checkbox"/> Community Self-Advocacy Training and Supports
<i>First Appointment Date:</i> _____ |
| <input type="checkbox"/> Caregiver/Family Supports and Services
<i>First Appointment Date:</i> _____ | |

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Patient/Member Name

MVP Member ID No.

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

Desired Goal or "Need" to be addressed: *