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 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

Referal 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.

- ☐ **Community Habilitation**
  First Appointment Date: _____
- ☐ **Day Habilitation**
  First Appointment Date: _____
- ☐ **Respite**
  First Appointment Date: _____
- ☐ **Prevocational Services**
  First Appointment Date: _____
- ☐ **Supported Employment**
  First Appointment Date: _____
- ☐ **Caregiver/Family Advocacy & Support Services**
  First Appointment Date: _____
- ☐ **Palliative Care Pain & Symptom Management**
  First Appointment Date: _____
- ☐ **Palliative Care Massage Therapy**
  First Appointment Date: _____
- ☐ **Palliative Care Expressive Therapy**
  First Appointment Date: _____
- ☐ **Palliative Care Counseling & Support Services**
  First Appointment Date: _____

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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: