# INSTRUCTIONS FOR COMPLETING THE COMPREHENSIVE MEDICAID CASE MANAGEMENT (CMCM) PROVIDER TRANSFER REQUEST

## CMCM AGENCY

Use this form to transfer a client from another CMCM agency to your agency.

**ENROLLMENT FORM**

1. Fill in the required information for your agency, the client, and the current CMCM provider, including:

- ♦ PROVIDER NUMBER: If you do not know the current agency's 8-digit provider number, leave the box blank.
- ♦ THRU DATE: Enter the current provider's last day of service.
- ♦ FROM DATE: The "From" date is the transfer date. Enter the date that your agency will begin CMCM services. It must be at least one day after the "Thru" date of the former CMCM
- ♦ REQUESTING PROVIDER AUTHORIZED SIGNATURE: Only the NYS authorized representative of your agency must sign this form. By signing, s/he certifies the validity of the data submitted.

2. Mail the completed form to the representative of the Local District Department of Social Services in your county. Be sure to include a self-addressed stamped return envelope with your change forms. **Be sure to keep a copy for your files.**

- ♦ **In 30 days, check your copy to be sure that you have received successful changes from the LDSS for the requested clients. You may bill one day after the date the LDSS signed enrollment request has been returned to you from the Local District. If you have not received the returned form, or if, after 30 days, there is a question concerning the CMCM changes, contact your Local Social Services District worker.**

## LDSS

1. When the information submitted by the agency is entered into the WMS R/E Subsystem, check the box "Successful Data Entry".
2. If the information supplied could not be entered into WMS, circle one of the choices given for "Unable to Process" or specify the reason under "other".
3. If the client is already enrolled in another CMCM program, LDSS staff should provide the name and address of the other CMCM agency.
4. **Mail the completed signed and dated form back to the CMCM agency in the provided envelope. Retain a copy for your records.**

**COMPREHENSIVE MEDICAID CASE MANAGEMENT (CMCM) PROVIDER TRANSFER REQUEST**

| **REQUESTING (NEW) CMCM PROVIDER AGENCY:** | **CURRENT (OLD) CMCM PROVIDER AGENCY:** |
|---|---|
| AGENCY NAME:_______________________________<br>AGENCY ADDRESS:____________________________<br>ZIP CODE:__________PHONE: (___)_______________ | AGENCY NAME:_____________________________<br>ADDRESS:__________________________________<br>ZIP CODE:__________PHONE: (___)____________<br>FAX NUMBER:(___)__________________________ |

| **Client Name (Last, First):** | | **CIN:** | **Case Number:** | |
|---|---|---|---|---|
| **Current CMCM ID:** | **New CMCM ID:** | | **Thru Date (MMDDYY):** | **From Date (MMDDYY):** |

**Requesting CMCM Provider Certification**: In signing this form, the agency attests to the following for each individual enrolling in CMCM: 1. Each client is part of the targeted population and verification of this is in the case record. 2. Each client understands the voluntary nature of CMCM and freely accepts services form this agency. 3. The client's signed statement is in the case record.
If the client is enrolled in another CMCM and this agency is satisfied that they are the sole provider of CMCM services, this agency will notify the current CMCM provider of this transfer and the From Date, and will send the current CMCM provider a copy of this form.
**Client Signature**:___________________________________________________________________________**Date**:__________________
**Requesting Provider Authorized Signature**:______________________________________________________**Date**:_________________

**UNABLE TO PROCESS CODES**

1. CURRENT RESTRICTION ALREADY EXISTS_____________________________________________________________
2. INDIVIDUAL HAS NO MA COVERAGE FOR ENROLLMENT REQUEST_______________________________________
3. NO DISENROLLMENT REQUIRED_____________________________________________________________________
4. SPECIFIED CLIENT NOT FOUND IN DATABASE___________________________________________________
5. OTHER (EXPLAIN)_________________________________________________________________________________

**LDSS**

Input Date__________________ Y Successful Data Entry Unable to Process Reason (circle) 1 2 3 4 5_________________

LDSS Signature_________________________________________ Phone (____)___________________________________________