MODULE 1: COMPLETING PCS FORM DMA 3051

NEW REFERRAL

Liberty Healthcare Corporation of North Carolina

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For NEW Referral Requests, Complete The Following Sections

Section A	• Recipient Demographics
Section B	• Recipient Medical History
Section C	• New Referral Request

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New Referral: Section A Required Fields

- Medicaid ID Number – Only active Medicaid participants are eligible.
- Enter Recipient Name, Date of Birth, Address and Phone.
- Indicate the recipient's alternate contacts: parent, guardian or legal representative.
- PCS Provider name and phone should reflect the current provider information when submitting.

SECTION A. RECIPIENT DEMOGRAPHICS

Medicaid ID#: _____

Recipient's Name (as shown on Medicaid Card) First: _____ MI: ____ Last: _____

Date of Birth: _____ (mm/dd/yyyy) **Gender:** ☐ Male ☐ Female **Primary Language:** ☐ English ☐ Spanish ☐ Other

Address: _____ **City:** _____

County: _____ **Zip:** _____ (zip code + 4 digit extension) **Phone:** _____

Alternate Contact/Parent/Guardian (required if patient under 18)**: First:** _____ **Last:** _____

Relationship to Patient: _____ **Phone:** _____

Provider Name (if applicable) _____ **Provider Phone:** _____

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New Referral: Section B Required Fields

- Enter the Medical Diagnosis and ICD-9 Code.
- Enter "O" or "E" for Onset or Exacerbation.
- Where known, enter the diagnosis date in mm/yyyy format. The date reflects either the date of onset, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. Note that the date of onset or exacerbation must be as close to the actual date as possible.
- If the precise date is unknown, enter 00s in the month and note the year.

SECTION B. RECIPIENT'S MEDICAL HISTORY - complete this section only if submitting a NEW REFERRAL or CHANGE OF STATUS request.

List ***both*** the current **medical diagnoses** and **ICD-9 codes** that currently limit patient's ability to independently perform Activities of Daily Living (bathing, dressing, mobility, toileting, and eating), prepare meals, and manage medications.

Medical Diagnosis	ICD-9 Code	Enter "O" for Onset or "E" for Exacerbation	Date (mm/yyyy)

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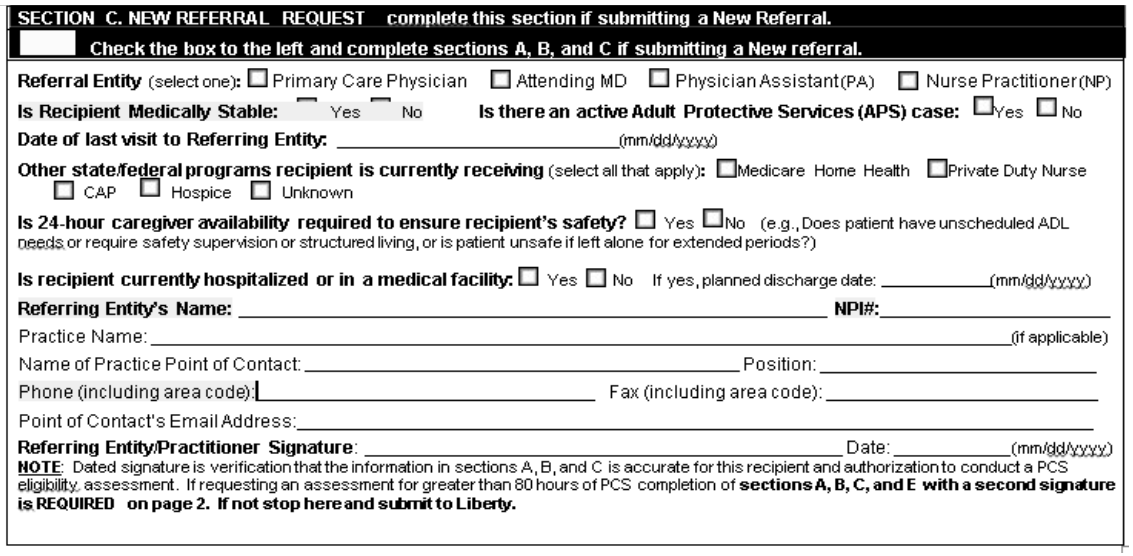
New Referral: Section C Required Fields

- Indicate if the recipient is medically stable.
- Provide Referring Entity's name, NPI and phone number.
- The last visit date must be completed and must have occurred within 90 days of the Request For Services Form submission date. List the date in mm/dd/yyyy format.
- The Request For Services Form for the New Referral MUST be signed by the referring entity: an MD/NP/PA. The signature date must be in mm/dd/yyyy format.



SECTION C. NEW REFERRAL REQUEST complete this section if submitting a New Referral.

☐ **Check the box to the left and complete sections A, B, and C if submitting a New referral.**

Referral Entity (select one): ☐ Primary Care Physician ☐ Attending MD ☐ Physician Assistant(PA) ☐ Nurse Practitioner(NP)

Is Recipient Medically Stable: ☐ Yes ☐ No **Is there an active Adult Protective Services (APS) case:** ☐ Yes ☐ No

Date of last visit to Referring Entity: _____(mm/dd/yyyy)

Other state/federal programs recipient is currently receiving (select all that apply): ☐ Medicare Home Health ☐ Private Duty Nurse ☐ CAP ☐ Hospice ☐ Unknown

Is 24-hour caregiver availability required to ensure recipient's safety? ☐ Yes ☐ No (e.g., Does patient have unscheduled ADL needs or require safety supervision or structured living, or is patient unsafe if left alone for extended periods?)

Is recipient currently hospitalized or in a medical facility: ☐ Yes ☐ No If yes, planned discharge date: _____(mm/dd/yyyy)

Referring Entity's Name: _____ **NPI#:** _____

Practice Name: _____(if applicable)

Name of Practice Point of Contact: _____ Position: _____

Phone (including area code): _____ Fax (including area code): _____

Point of Contact's Email Address: _____

Referring Entity/Practitioner Signature: _____ Date: _____(mm/dd/yyyy)

NOTE: Dated signature is verification that the information in sections A, B, and C is accurate for this recipient and authorization to conduct a PCS eligibility assessment. If requesting an assessment for greater than 80 hours of PCS completion of **sections A, B, C, and E with a second signature is REQUIRED on page 2. If not stop here and submit to Liberty.**

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New Referral: Sending The Completed Form

- Complete Sections A, B & C.
- Please fax Page 1 of the completed form to:
  919-307-8307 or 855-740-1600 (toll-free)
- If you prefer, you may mail Page 1 of the form to:

  Liberty Healthcare Corporation of NC

  Attn: Referral Processing Department
  5540 Centerview Drive, Suite 114
  Raleigh, NC 27606
- If you have questions concerning the form, please email NCfax@libertyhealth.com or call 855-740-1400.
- Keep copies of all forms and fax confirmations for your records.

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New Referral: What Happens Next

- If the New Referral Request is complete and meets the requirements as outlined in *Clinical Coverage Policy 3L,* the Referral will be processed and entered into QiRePort.
- If the information is not complete, the New Referral Request form will be returned by Liberty Healthcare to the referring entity via fax within 48 hours.
- Liberty Healthcare will verify that the recipient has active Medicaid coverage. The recipient will be contacted by Liberty Healthcare to schedule a Medicaid PCS eligibility assessment.
- If the recipient is determined to be eligible for PCS, the Provider of Choice will receive the referral via the QiRePort Provider Interface.