Personal Care Services (PCS) ICD-10 Transition Form

PCS is a Medicaid benefit based on an unmet need for assistance with Activities of Daily Living (ADLs), which means bathing, dressing, toileting, eating, and mobility in the setting of care.

All Health Insurance Portability and Accountability Act (HIPAA) covered entities are required to use ICD-10 diagnosis and procedure codes for dates of service on or after October 1, 2015. ICD-9 diagnosis and procedure codes can no longer be used for health care services provided on or after this date.

Completed form should be faxed to Liberty Healthcare Corporation-NC at 919-307-8307 or 855-740-1600 (toll free) or uploaded into QiReport Supporting Documents. For questions, call 855-740-1400 or 919-322-5944, or email: NC-IAsupport@libertyhealth.com.

This is a required form for current PCS beneficiaries.

SECTION A. BENEFICIARY DEMOGRAPHICS

Beneficiary's Name: First:______________________**MI**:___**Last**:______________________**DOB:**____/____/________

Medicaid ID#:___________________Gender: ☐ M ☐ F Language: ☐ English ☐ Spanish ☐ Other_________Address:__

____**City:** __________________________ **County:**___**Zip:**______

______________________________**Phone:** ____________

Alternate Contact (Non-PCS Provider)/Parent/Guardian (required if beneficiary < 18): Name: _____________________________

Relationship to Beneficiary:___________________________ Phone: ________________________________

Current PCS Provider Name:_________________________________**NPI**:________________**Phone**: _______________

Beneficiary currently resides: ☐ At home ☐ Adult Care Home ☐ Special Care Unit (SCU) ☐ Group Home

☐ Other ________________________________

SECTION B. BENEFICIARY'S CONDITIONS THAT RESULT IN NEED FOR ASSISTANCE WITH ADLS

Identify the current **medical diagnoses related to the beneficiary's need for assistance with** qualifying Activities of Daily Living (bathing, dressing, mobility, toileting, and eating). List *both* the diagnosis and the ICD-10 code for each.

Medical Diagnosis	ICD-10 Code (4 or 5 digits required)
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SECTION C. PRACTITIONER INFORMATION/Referral

Your signature below confirms that you recommend the beneficiary receive an annual assessment to determine the level of need for hands on assistance with ADLs.

Practitioner's Name:______________________________________**Practitioner NPI#:**___________________ **Select one:** ☐ Beneficiary's Primary Care Practitioner ☐ Outpatient Specialty Practitioner ☐ Inpatient Practitioner

Practice Name:____

Practice Contact Name: ____

Address:____

Phone (______)________________Fax (_______) _________________

Practice Stamp:

Practitioner Signature AND Credentials: ____ **Date:** ____/____/________

"I hereby attest that the information contained herein is current, complete, and accurate to the best of my knowledge and belief. I understand that my attestation may result in the provision of services which are paid for by state and federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement or representation may be prosecuted under the applicable federal and state laws."