Request for Reconsideration of PCS Authorization

North Carolina Department of Health and Human Services – NC Medicaid

Following an initial PCS Service Authorization for less than 80 hours per month, beneficiaries 21 years of age or older, may submit a Request for Reconsideration of PCS Authorization form to request additional hours. Reconsideration request must be received no earlier than 31 calendar days and no later than 60 calendar days from the date of the initial approval notification.

Completed form should be submitted to Liberty Healthcare Corporation-NC via fax to 919-322-5942 or 855-740-0200. For questions, call 855-740-1400 or 919-322-5944. Incomplete or illegible forms will not be processed.

Section A: Beneficiary Information

Beneficiary Demographics

Name: First: ______________________ MI: ______ Last: __________________ DOB: ____________

Medicaid ID: _________________________ Contact Number: __________________________________

Address (if Different from Initial Request): ____

City: _____________________________ County: ____________________ Zip: ____________

Alternate Contact (optional)

Name: First: ______________________________ MI: ______ Last: _____________________________

Relationship to Beneficiary: _______________________________ Phone: _______________________

Section B: Reconsideration

Please specify which ADL(s) and Task(s) are not being supported by the current authorized hours of PCS.

- ☐ Bathing
- ☐ Dressing
- ☐ Mobility
- ☐ Toileting
- ☐ Eating
- ☐ Other – If other, describe

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Section C: Supporting Documentation

Supporting documentation must be submitted that specifies, explains, and supports why more authorized hours of PCS are needed and which ADL(s) and Task(s) are not being met by the current hours. The documentation should also provide information indicating why the beneficiary believes that the prior assessment did not accurately reflect the beneficiary's functional capacity or why the prior determination is otherwise insufficient.

____ ____/____/________

Signature of Medicaid Beneficiary or Legal Guardian/POA **Date**

________________________________ ______________________________

Name (Print) **Relationship to Beneficiary**