

# MODULE 1: COMPLETING PCS FORM DMA 3051



CHANGE  
OF  
PROVIDER

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**For Change of Provider Requests,  
Complete The Following Sections**

Section A	<ul style="list-style-type: none"><li>• Recipient Demographics</li></ul>
Section F	<ul style="list-style-type: none"><li>• Change of Provider Request</li></ul>

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## Change of Provider: Section F Key Points

- A beneficiary may request Change of Provider by submitting this form or by calling Liberty Healthcare.
- If a beneficiary needs assistance in selecting an Alternate Preferred Provider, assistance can be provided by a Liberty Healthcare Customer Support Representative.
- Liberty Healthcare will confirm all Change of Provider requests with the Beneficiary or legal guardian.

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## Change of Provider: Section F Required Fields

- Recipient's Preferred Provider
  - Agency Name
  - Phone
  - NPI #
- Contact Information for Questions
  - Contact's Name
  - Phone

sections A, B and E are accurate for this recipient and authorization to conduct the PCS eligibility assessment.

**SECTION F. CHANGE OF PROVIDER REQUEST - complete this section if submitting a Change of Provider (COP).**

Check the box to the left and complete sections A and F only.

**Requested By** (select one):  Primary Care Physician  Attending MD  Physician Assistant  Nurse Practitioner  
 Recipient  Responsible Party

**NOTE:** Home Care Agencies and Licensed Residential Facilities should have beneficiaries or the recipient's legal representatives to call the Liberty Healthcare Corporation-NC Call Center for Change of Provider (COP) requests at 855-740-1400 or 919-322-5944. Home Care Agencies and Licensed Residential Facilities may assist the recipient or legal representative in placing the call.

**Reason for Provider Change** (select one):  
 Recipient or legal representative's choice  
 Current provider unable to continue providing services  
 Other: \_\_\_\_\_

**Status of PCS Services** (select one):  
 Discharged/Transferred on \_\_\_\_\_ (mm/dd/yyyy)  
 Scheduled for discharge/transfer on \_\_\_\_\_ (mm/dd/yyyy)  
 Continue receiving services until recipient is established with a new provider agency; no discharge/transfer is planned

**Recipient's Preferred Provider (select one):**

Home Care Agency  Family Care Home  Adult Care Home  Adult Care Bed in Nursing Facility  SLF-5600c  Special Care Unit (stand-alone Special Care Unit or SCU bed)

Agency Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Provider NPI#: \_\_\_\_\_ PCS Provider Locator Code#: \_\_\_\_\_ (three digit code)  
 Facility License # (if applicable): \_\_\_\_\_ License Date (if applicable): \_\_\_\_\_ (mm/dd/yyyy)  
 Physical Address: \_\_\_\_\_

**Recipient's Alternate Preferred Provider (select one)**

Home Care Agency  Family Care Home  Adult Care Home  Adult Care Bed in Nursing Facility  SLF-5600c  Special Care Unit (stand-alone Special Care Unit or SCU bed)

Agency Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Provider NPI#: \_\_\_\_\_ PCS Provider Locator Code#: \_\_\_\_\_ (three digit code)  
 Facility License # (if applicable): \_\_\_\_\_ License Date (if applicable): \_\_\_\_\_ (mm/dd/yyyy)  
 Physical Address: \_\_\_\_\_

**Contact Information for Questions about Change of Provider Request (if not recipient or alternate contact listed in section A).**

Contact's Name: \_\_\_\_\_ Relationship to Recipient: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

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## Change of Provider: Sending The Completed Form

- Complete Sections A & F.
- Please fax Page 1, 2 & 3 of the completed form to:  
**484-434-1571 or 855-740-0200 (toll-free)**
- If you prefer, you may mail Page 1, 2 & 3 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](mailto:NCfax@libertyhealth.com) or call 855-740-1400.
- Keep copies of all forms and fax confirmations for your records.