



Health Homes (HH) Managed Care Organizations (MCOs) Notification Form

Please print clearly or complete electronically – accuracy is important.

Complete this form to report enrollment of a member in your health home, the transfer of a member from the Iowa Department of Human Services (DHS) or another MCO, a change in tier for a member, or disenrollment of a member from your health home.

Please check the box by the impacted MCO and submit form as directed below:

- Fax to Amerigroup Iowa Inc. at 1-844-556-6125.
- Fax to AmeriHealth Caritas Iowa at 1-844-280-9130.
- Email to UnitedHealthcare Plan of the River Valley Inc. at uhc_iowa_healthhomes@uhc.com or fax to 1-855-237-0574.

Check one: <input type="checkbox"/> Enrollment <input type="checkbox"/> Change in tier <input type="checkbox"/> Disenrollment	<input type="checkbox"/> Other (specify) <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Reason for change (see back of this page if disenrollment):
		Effective date of change:

Section 1: Member Information

Name:	Date of birth:	Phone:
MCO-Assigned Member ID #:	Medicaid Member ID #:	
Home Address:		

Section 2: Provider Information

Health Home Name:
National Provider Identifier (NPI) #:
MCO-Assigned Provider #:
Primary Care Provider:

Section 3: Enrollment

Integrated Health Home (check all that apply)		Tier Level (check one)	
<input type="checkbox"/> Psychotic Disorders <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Schizoaffective Disorder <input type="checkbox"/> Major Depression <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Obsessive-compulsive disorder <input type="checkbox"/> Delusional Disorder	<input type="checkbox"/> Serious Emotional Disturbance in Children <input type="checkbox"/> Mental Health Condition Resulting in Functional Impairment Note: Explain functional limitations on the back of this page.	<input type="checkbox"/> 5. Adult Non-Habilitation <input type="checkbox"/> 6. Child Non-Children's Mental Health (MH) Waiver <input type="checkbox"/> 7. Habilitation <input type="checkbox"/> 8. Children's MH Waiver If Tier 7 or 8, assessment date:	
Chronic Condition Health Home (check all that apply)		Patient Tier Assessment Tool (PTAT)	
<input type="checkbox"/> Mental Health Condition <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease	<input type="checkbox"/> BMI over 25 or child BMI >85th Percentile <input type="checkbox"/> Hypertension <input type="checkbox"/> At risk for another condition (list risk): <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Assessment Date:	
		Tier Level (check one)	
		<input type="checkbox"/> 1 – 3 Conditions <input type="checkbox"/> 4 – 6 Conditions <input type="checkbox"/> 7 – 9 Conditions <input type="checkbox"/> 10+ Conditions	

Health Home Case Manager signature:	
Phone:	Date:

Submission of enrollment form does not guarantee enrollment or payment for the health home. Members must meet Iowa Medicaid eligibility guidelines for successful enrollment.



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Reason for Disenrollment (check one)

- | | |
|--|--|
| <input type="checkbox"/> Member requested. | <input type="checkbox"/> Member is effectively self-coordinating services. |
| <input type="checkbox"/> Member not participating or provider unable to reach. | <input type="checkbox"/> Member is deceased. |
| <input type="checkbox"/> Member changed MCOs or DHS. | <input type="checkbox"/> Member has lost Medicaid eligibility long term. |
| <input type="checkbox"/> Member transferred to another health home. | <input type="checkbox"/> Provider requested. |
| <input type="checkbox"/> Member moved from the area. | <input type="checkbox"/> Provider terminated member enrollment. |
| <input type="checkbox"/> Member no longer meets criteria for health home. | |

Explain Functional Limitations: