Health Homes Managed Care Organizations (MCOs) Notification

Please print clearly or complete electronically — accuracy is important. Complete this form to request 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. *Submission of enrollment form does not guarantee enrollment or payment for the health home. Members must meet Iowa Medicaid eligibility guidelines for successful enrollment.*

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

☐ Fax to Amerigroup Iowa, Inc.: 844-556-6125 ☐ Fax to Iowa Total Care: 833-864-9673

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: Status

☐ Enrollment ☐ Change in tier IHH Choose an item. ☐ Change in tier CCHH

☐ Disenrollment Choose an item. ☐ Other (specify)

Effective Date of Change:

Section 4: Enrollment

Integrated Health Home (IHH)	Tier Level (check one)
The member's mental, behavior, or emotional disorder specified within the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association or its most recent International Classification of Diseases that causes serious functional impairment that substantially interferes with or limits one or more major life activities including functioning in the family, school, employment or community. **Attach clinical documentation, dated within the last 365 days, that includes diagnosis, functional limitations and mental health professional signature. Enrollments without this information will not be processed. Qualifying Diagnosis Codes:**	Choose an item.

Chronic Condition Health Home (CCHH) (check all that apply)			Patient Tier Assessment Tool (PTAT)	
☐ Mental Health Condition	☐ Chronic Pain	☐ Heart Disease	Assessment Date:	
☐ Substance Use Disorder	☐ COPD	☐ Hypertension		
☐ Asthma	☐ Diabetes		Tier Level (check one)	
☐ BMI over 24 or child BMI>85th Percentile			Choose an item.	
☐ At risk for another condition (list risk):				

Health Home Staff Signature:	
Phone:	Date: