Chronic Condition Health Home 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 applicable MCO and submit form as directed below:

☐ **Fax to Amerigroup Iowa Inc.: 844-556-6125** ☐ **Fax to Iowa Total Care: 833-864-9673 or upload via Client Portal**

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 Name:	

Section 3: Status
☐ Enrollment
☐ Renewal (for ITC only, for AGP complete through HIP)
☐ Disenrollment Choose an item Additional Information:
Effective Date of Change:

Section 4: Enrollment	
Conditions- select all that apply: ☐ Mental Health Condition ☐ Chronic Pain ☐ Heart Disease ☐ Substance Use Disorder ☐ COPD ☐ Hypertension ☐ Asthma ☐ Diabetes ☐ BMI over 24 or child BMI>85th Percentile ☐ At risk for another condition (list risk):	**Tier Level** (check one) ☐ Tier 1: 1-3 Conditions ☐ Tier 2: 4-6 Conditions ☐ Tier 3: 7-9 Conditions ☐ Tier 4: 10+ Conditions **Patient Tier Assessment Tool (PTAT) Date:**
Health Home Staff Signature:	
Phone:	Date: