Enhanced Care Management(ECM)

Provider Reassignment Request (FORM I)

CenCal HEALTH
Local. Quality. Healthcare.

Member and Provider Information

Medi-Cal ID Number:	**Authorization Number:**
Member Name:	**Date of Birth:**

Provider Reassignment Requested by:

❑ Member
❑ Authorized Representative or Legal Guardian
❑ ECM Provider

Name of Provider Requesting Reassignment:	**Phone Number:**

Current ECM Provider, if Known:

ECM Population of Focus (POF) (select all that apply)

❑ Individuals & Families Experiencing Homelessness	❑ Birth Equity Population of Focus (Adults and Youth)
❑ Adults at Risk for Avoidable Hospital and Emergency Department (ED) Utilization	❑ Children and Youth at Risk for Avoidable Hospital or ED Utilization
❑ Adults with Severe Mental Health and/or Substance Use Disorder (SUD) Needs	❑ Children and Youth with Serious Mental Health and/or SUD Needs
❑ Adults Transitioning from Incarceration	❑ Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition
❑ Adults Living in the Community at Risk for Long-Term Care Institutionalization (LTC)	❑ Children and Youth Transitioning from Incarceration
❑ Adult Nursing Facility Residents Transitioning to the Community	❑ Children and Youth Involved in Child Welfare
❑ Adults with an I/DD	❑ Children and Youth with an I/DD
❑ Homeless Families or Unaccompanied Children/ Youth	

Reassignment Reason (select only one)

❑ Member is requesting assignment to a new ECM Provider
***Name of Provider the Member wants to be reassigned to*:**

❑ Member's behavior or environment is unsafe for the ECM Provider and Member would like to continue receiving ECM services

❑ Member moved and ECM Provider does not serve that County (i.e. *Moved to San Luis Obispo and Provider only Serves Santa Barbara County*)

Additional Information (Request reason, collaboration with current ECM provider):

Member Consent

☐ Member agreed to a new ECM Provider assignment Date:

New Provider Assignment

Provider Assignment Effective Date (CenCal Use Only):

Form Completed by (Name) **Signature**

Please allow 30 days to process reassignment request

Please send via secure link https://gateway.cencalhealth.org/form/ecm