

Idaho Medicaid Enhanced Plan Request Form
Children's DD Services
(Department Use Only - IDHW - H0002)

Directions: Please fill in all blanks, print and sign the form, submit to Idaho Falls Processing Center by fax at 208-528-5933 or 1-888-532-0014. You may choose to submit the form electronically to: HCCR7@dhw.idaho.gov (global - Healthy Conn Reg7 Consolidated Unit)

Maintain original in participant's records.

IDENTIFYING PARTICIPANT INFORMATION

Name of Participant: _____

Medicaid ID#: _____

CERTIFICATION

I have assessed on _____ and certify

that the participant meets the requirements in IDAPA 16.03.10 for receiving the above services in the Medicaid Enhanced Plan.

Please start enhanced services effective _____.

DHW employee,

DHW Fax # (208) _____

Please type your name in space provided to electronically sign this form

Date

Please contact 1-888-528-5861 for additional information