DEPARTMENT OF HEALTH & HOSPITALS
Long Term-Personal Care Services Program

Provider Name
Street Address
City, LA Zip Code

Date

Recipient Name

Recipient Number

PROVIDER NOTICE

Dear_____:

This letter is to notify your agency of the following regarding Medicaid Long Term-Personal Care Services (LT-PCS):

☐ We have been notified by the above named recipient that your agency was selected and has agreed to provide LT-PCS. Before services can be authorized, you must submit a signed Agreement to Provide Services. This information must be received within **14 days** of the date of this notice to the following address/fax:

Affiliated Computer Services
5700 Florida Blvd.
13th Floor
Baton Rouge, LA 70806
Fax: (225) 231-8151
Attn: Long Term-Personal Care Services

☐ We notified you on ___(date of notice of selection letter)__ that your agency was selected to provide LT-PCS to the above named recipient. As of this date, we have not received the required information as indicated below:

_____ A signed copy of your Agreement to Provide Services.

Since we have been unsuccessful in reaching you by telephone, we are requesting that you contact our office by __(5 days from date of this letter)_____ to discuss this matter. **Failure to contact this office may result in the recipient selecting another provider.**

☐ We have been notified that the above named recipient wishes to change LT-PCS providers. Effective _____ your authorization to provide these services to this recipient will end.

NOTE: PRIOR AUTHORIZATION WILL BE EFFECTIVE THE DATE THE AGREEMENT TO PROVIDER SERVICE IS APPROVED. PAYMENT WILL NOT BE MADE FOR SERVICES PROVIDED PRIOR TO THE AUTHORIZATION DATE.

_____
Agency Representative

_____
Phone Number

LT-PCS 3 Provider Notice
Issued 02/13/04
Reissued 03/02/2009

DEPARTMENT OF HEALTH & HOSPITALS
Long Term-Personal Care Services Program

Recipient Name
Street Address
City, LA Zip Code

Date

Recipient Name

Recipient Number

Recipient Phone Number

Personal Representative Name

PROVIDER NOTICE – STATUS CHANGE REVIEW

Dear_____:

The above named recipient has been approved for additional service units. This change is effective _____ through _____. Before these services can be authorized, you must submit a signed Agreement to Provide Services. Please submit this information within **3 days** to Affiliated Computer Services (ACS) at fax number **(225) 231-8151**.

This change will not be implemented until ACS receives an Agreement to Provide Services signed by both the provider agency and the recipient/personal representative.

Failure to timely submit this information to ACS may result in the recipient selecting another provider.

_____
Agency Representative

_____
Phone Number

LT-PCS 3 A Provider Notice-Status Change Review
Issued 09/02/04
Reissued 03/02/2009

DEPARTMENT OF HEALTH & HOSPITALS
Long Term-Personal Care Services Program

Recipient Name
Street Address
City, LA Zip Code

Date

Recipient Name

Recipient Number

PROVIDER NOTICE – REASSESSMENT

Dear_____:

☐ The above named recipient has been approved for personal care services for the new certification period _____ through _____. Before these services can be authorized, you must submit a signed Agreement to Provide Services. Please submit this information within **5 days** of the date of this notice to the following address or fax number:

Affiliated Computer Services
5700 Florida Blvd.
13th Floor
Baton Rouge, LA 70806
Fax: (225) 231-8151
Attn: Long Term -Personal Care Services

☐ We notified you on _____that the above named recipient was recertified effective _____through _____. As of this date, we have not received the required information as indicated below:

_____A signed Agreement to Provide Services

Since we have been unsuccessful in reaching you by telephone, we are requesting that you contact our office by _____ to discuss this matter. **Failure to contact this office may result in the recipient selecting another provider.**

_____
Agency Representative

_____
Telephone Number

LT-PCS 13 C Provider Notice-Reassessment
Issued 05/11/05
Reissued 06/20/2007