

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX A – LT-PCS CORRESPONDENCE

PAGE(S) 2

Bobby Jindal
GOVERNORKathy H. Kliebert
SECRETARYState of Louisiana
Department of Health and Hospitals
Office of Aging and Adult Services

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:

Xerox State Healthcare, LLC
2900 Westfork Drive
Suite 540
Baton Rouge, LA 70827
Fax: (866) 246-8511
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 _____ to discuss this matter. **Failure to contact this office may result in the recipient selecting another provider.**

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX A – LT-PCS CORRESPONDENCE

PAGE(S) 2

Provider Notice
Page 2

☐ 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 PROVIDE SERVICE IS APPROVED. PAYMENT WILL NOT BE MADE FOR SERVICES PROVIDED PRIOR TO THE AUTHORIZATION DATE.

XEROX State Healthcare, LLC
Agency Representative

(877) 456-1146
Telephone Number