* = Required Field

SmartCareMCO New Member Enrollment/ClientID Request Form

PartnerSolutions
PartnerSolutions.org

*OhioMHAS Board Consortium | ClientID No. | *Form Type

Provider Information

*Submitting Provider | *UPI | Requested Date | *Fax No. | *Phone No.

Client Information

*First Name | Middle Name | *Last Name | Suffix

*SSN | ☐ Client doesn't have an SSN. | *DOB | *Sex | *Primary Language (English)

*Ethnicity | *Race (Check all that apply.) | * Marital Status

*Race (Check all that apply.)
- ☐ White
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ Asian
- ☐ Client Refused/ Doesn't Know

Residency and Contact Information

*Address 1 | Address 2 (e.g., Apt., Lot, Unit)

*City | *State (OH) | *ZIP | *County of Residence | *County of Financial Responsibility

Primary Phone No. | Secondary Phone Number | Affiliation Code | Affiliation Code Start Date | Affiliation Code End Date

Additional Information

Special Populations

IDAT Funding (House Bill 131): ○ Yes ○ No ○ N/A

Notes

Coverage and Financial Information

*Effective Date | *Household Size | *Adjusted Gross Monthly Income | Medicaid ID | Medicaid Managed Care Plan

Verifications

1.) *Disclosure of enrollment?	○ Yes ○ No		4.) Client is potentially SPMI/SED?	○ Yes ○ No ○ N/A	Prohibition on Redisclosure: 42 CFR Part 2 prohibits unauthorized disclosure of these records.
2.) *All applicable authorizations for billing as required by Federal and State laws have been received?	○ Yes ○ No		5.) Residency verification form signed?	○ Yes ○ No ○ N/A	
3.) *In crisis at enrollment?	○ Yes ○ No		6.) Proof of household income?	○ Yes ○ No ○ N/A	
			7.) Proof of identity?	○ Yes ○ No ○ N/A	

Items Completed by Enrollment Staff

Client Copay | Client Plan | Staff Entering Data | Date Entered