* = 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.)

☐ White
☐ American Indian or Alaskan Native
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ Asian
☐ Client Refused/ Doesn't Know

*Marital Status

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

2.) *All applicable authorizations for billing as required by Federal and State laws have been received? ◯ Yes ◯ No

3.) *In crisis at enrollment? ◯ Yes ◯ No

4.) Client is potentially SPMI/SED? ◯ Yes ◯ No ◯ N/A

5.) Residency verification form signed? ◯ Yes ◯ No ◯ N/A

6.) Proof of household income? ◯ Yes ◯ No ◯ N/A

7.) Proof of identity? ◯ Yes ◯ No ◯ N/A

Prohibition on Redisclosure: 42 CFR Part 2 prohibits unauthorized disclosure of these records.

Items Completed by Enrollment Staff

Client Copay

Client Plan

Staff Entering Data

Date Entered