CHOICES RE-ENROLLMENT FORM
MEMBER WITHDRAWAL OF ELECTION OF HOSPICE SERVICES

To be Completed by NF and submitted to MCO

Member Last Name_____ Member First Name_____ MI____

Member DOB_____/_____/_____ Member SSN _____-_____-_____

Nursing Facility Name: _____ _____

NF E-mail address_____ NF Fax Number _____

Submitter Name: _____ Submitter Phone Number: _____

Hospice effective date ____/____/_____

CHOICES Re-Enrollment requested effective date ____/____/_____

Detailed description of circumstances surrounding reasons for withdrawal of hospice services:

***Note: this information will be used to approve or deny the request for CHOICES re-enrollment. Please be detailed and specific in your description.**

Is there more than 30 days from the hospice effective date and the re-Enrollment requested effective date?

☐ **Yes, new PAE required** ☐ **No**

Prior to hospice, was the patient receiving NF service with an Approved PreAdmission Evaluation (PAE) for the level of care to be provided?

☐ **Yes** TPAES Control Number_____ ☐ **No, New PAE required**

Has patient had a change in the level of care since the above PAE was approved?

☐ **Yes, new PAE required** ☐ **No**

Did patient discharge home from the Nursing Facility at any point since the above PAE was approved?

☐ **Yes, new PAE required** ☐ **No**

***Note: If a new PAE is required, do not submit this form**

Check Member's MCO below and fax or email COMPLETED form to the Member's MCO at the number listed below:

☐ **United HealthCare**	☐ **AmeriGroup**	☐ **BlueCare/TennCare Select**
1-888-582-1963	**1-888-280-3736**	**855-273-5838**
tn_ltc_choices_cma@uhc.com	tntransitions@amerigroupcorp.com	CHOICESNFforms_gm@bcbst.com