Conflict Free Service Coordination

Choice Form

Agency Name:

_____

Medical Assistance (PROMISe™) Provider Number and Service Location(s)

_____ _____ _____

Please check one of the boxes below to indicate your decision and return it to the Bureau of Provider Support, Certification and Enrollment Section by June 15, 2012. This form can be emailed to RA-hcbsenprov@state.pa.us or faxed to 717-772-0965.

☐ Our agency will continue to provide Service Coordination and is requesting that all direct services be removed from our provider profile.

☐ Our agency will continue to provide direct services and is requesting that all Service Coordination services be removed from our provider profile.

☐ Our agency is willing to accept new participants for Service Coordination, due to other SCEs choosing to be a direct service provider only.

_____ _____

Signature of Authorized Representative Title

_____

Printed Name of Authorized Representative

_____

Date