



WAIVER PROVIDER FILE MAINTENANCE REQUEST FORM

Provider Number	Provider Name	Date of Request
Requestor (Waiver Coordinator)	Coordinator Signature	Contact Number

The Medicaid fiscal agent is directed to process the request as indicated below:

Waiver Program Eligibility: **Approve** **Terminate**

NOTE: Attach a copy of term letter to provider.

Check the appropriate box for the waiver program to approve or terminate including the Effective Date.

Specialty Code and Description	Contract	Effective Date
<input type="checkbox"/> 096-Developmental Disability	Developmental Disability	
<input type="checkbox"/> 098-Family Supported Living	Family Supported Living	
<input type="checkbox"/> 068-Consumer Directed Care	Consumer Directed Care	
<input type="checkbox"/> 089-Assisted Living for the Elderly	Assisted Living	
<input type="checkbox"/> 095-Aged/Disabled Adult	Aged/Disabled Adult	
<input type="checkbox"/> 079-Traumatic Brain/Spinal Cord Injury	Traumatic Brain/Spinal Cord Injury	
<input type="checkbox"/> 112- Adult Cystic Fibrosis	Adult Cystic Fibrosis	
<input type="checkbox"/> 094-Model	Model	
<input type="checkbox"/> 097-Channeling	Channeling	
<input type="checkbox"/> 099-Project Aids Care	AIDS Project	
<input type="checkbox"/> 110-Familial Dysautonomia	Familial Dysautonomia	
<input type="checkbox"/> 111-Alzheimer's	Alzheimer's Disease	
<input type="checkbox"/> 113- Adult Day Care	Adult Day Health	

Group Membership: **Add** **End**

NOTE: The group provider must be enrolled in the same waiver program as the provider in order for them to be linked.

Group Medicaid ID	Group Provider Name	Effective Date
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Change of Address:

NOTE: Attach serialized Change of Address form.

Electronic Funds Transfer Authorization (EFT):

NOTE: Attach EFT form with bank letter or voided check..