myIL aces$ FINANCIAL MANAGEMENT SERVICES

ACES$ MCC of VA Commonwealth Coordinated Care Plus Program

Enrollment Packet Referral Request Form

Initial Referral Date: _____

Reason for Request:

- ☐ New Member
- ☐ Eligibility Change
- ☐ Plan Change
- ☐ Employer of Record Change
- ☐ Existing Consumer/Attendant Change
- ☐ Existing Consumer/SF Change

MEMBER INFORMATION

NOTE: ***All items with an *asterisk are required. Medicaid eligibility must be active to process this request.***

*Name: _____ (First) _____ (Last) _____ (MI)

*Date of Birth: _____ *Medicaid ID: _____ *SSN: _____

*Physical Address: _____

Mailing Address: _____

Phone: _____ Gender: _____

Email: _____

EMPLOYER of RECORD INFORMATION

NOTE: ***All items with an *asterisk are required. Please make sure the name and SSN match what is listed on the Social Security Card. A physical address is required to process this request.***

Employer of Record different than Member? ☐ Yes ☐ No ***If Yes, please complete the following information***

Existing Employer of Record? ☐ Yes ☐ No ***If Yes, please provide EIN:*** _____

*Name: _____ (First) _____ (Last) _____ (MI)

Date of Birth: _____ *SSN: _____

*Physical Address: _____

Mailing Address: _____

Phone: _____ *Email: _____

ATTENDANT INFORMATION

Name: _____

Complete Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

SERVICE FACILITATOR INFORMATION

Service Facilitator Name: _____

Email: _____ Phone: _____

Agency: _____ NPI#: _____

Comments: _____

FORM SUBMISSION

To submit your request fax or email:

Fax: 1 (888) 862-3840 or Email: SupportVA@mycil.org