**Detroit Wayne Integrated Health Network** AUTISM APPLIED BEHAVIOR ANALYSIS BENEFIT **CASE TRANSFER & CASE RE-ENTRY FORM**

* ASD Provider Transfer ☐ ASD Benefit Re-entry

**1. Member Name:**

**3. MHWIN Member ID #:**

**2. Medicaid ID #:**

1. **Previous Provider**

□ Acorn Health

□ Attendant Care

□ Behavior Frontiers

□ Centria

□ Chitter Chatter

□ Gateway

□ HealthCall

□ Merakey

□ MetroEHS

□ ODLA

□ Patterns

□ Positive

□ TCC

□ TGC

□ Total Spectrum

□ Social Care Admin.

□ Sprout

□ Zelexa

□ Other (specify): \_\_\_\_\_\_\_\_\_

1. **New ASD Provider**

□ Acorn Health

□ Attendant Care

□ Behavior Frontiers

□ Centria

□ Chitter Chatter

□ Gateway

□ HealthCall

□ Merakey

□ MetroEHS

□ ODLA

□ Patterns

□ Positive

□ TCC

□ TGC

□ Total Spectrum

□ Social Care Admin.

□ Sprout

□ Zelexa

□ Other (specify): \_\_\_\_\_\_\_\_

1. **Request Date: 9. New Provider Case Acceptance Date:**
2. **Was the Previous ASD Provider Notified:** ☐ Yes ☐ No

Date, Contact Name & email:

1. **Was the New ASD Provider Notified:** ☐ Yes ☐ No

Date, Contact Name & email:

1. **Was the IPOS Case Holder Notified:** ☐ Yes ☐ No

Date, Contact Name & email:

1. **Were all authorizations from the previous provider early terminated?** ☐ Yes ☐ No ☐ UNK Date:

***Comments:*** *(Must indicate family reason for case transfer request; Must indicate reason for previous discharge, including any barriers and what is being put in place to ensure success in current enrollment request)*

Name of Person Completing Form:

Provider Agency Completing Request:

Revised: 1.5.22 UPLOAD FORM TO MH-WIN SCANNED DOCUMENTS AND REQUEST AUTHORIZATION FOR CONTINUED SERVICE PREVIOUS & NEW ASD PROVIDERS PLEASE INCLUDE CASE TRANSFER ON MONTHLY LOG – TRANSFER TAB