Person-Centered Medical Home
PCMH & Glide Path Change Request Form

Revision E – March 12, 2018

I. Instructions to Complete the PCMH and Glide Path Change Request Form

Please note for FQHC-PCMH Accreditation Participants, Section E and fields H.12 and H.13 are not applicable.

The following change(s) can be made by using this form:

a. Add or remove a practitioner from the Person-Centered Medical Home (PCMH) or Glide Path practice
b. NCQA recognition level change
c. Notification of an address change
d. Notification of a practice change such as addition of a group billing number, practice name change, or merger/acquisition
e. Notification of a site termination from the Department of Social Services ("the Department" or DSS) PCMH Program

Contact your Community Practice Transformation Specialist (CPTS) at Community Health Network of Connecticut, Inc. (CHNCT), to discuss changes you wish to make that are not indicated. You may call 203.949.4194 to obtain the assigned CPTS contact information for your practice, if needed.

To add a new PCMH, Glide Path, or FQHC-PCMH Accreditation practice site, it is necessary to complete a new PCMH and, if applicable, Glide Path application.

Please note:

- Changes to add or remove practitioners will be made to all practice sites. For practices with multiple site locations, enter any DSS approved PCMH site address associated with the practice in lines A.4-A.8.
- All practitioners being added **MUST** have an active Medicaid CMAP/AVRS number prior to completing this form. Effective dates for these transactions listed in Section I must be on or after the effective dates assigned by Gainwell Technologies.
- If a practitioner is not actively enrolled in the Connecticut Medical Assistance Program, the provider must do so before they can be added to a PCMH or Glide Path practice. Providers can enroll at www.ctdssmap.com by selecting **Provider**, then **Provider Enrollment**. Once enrolled, the practice may then use this form to request practitioners be added to their PCMH, Glide Path, or FQHC-PCMH Accreditation practice site.
- To ensure your practice receives the fee differential payments for primary care services, your service location address submitted on your claim **MUST** exactly match the primary or alternate service location address on Gainwell Technology's system.
- Prior to notifying CHNCT of a practitioner add or removal, a practice change, or an address change to an existing PCMH, Glide Path, or FQHC-PCMH Accreditation practice site, or if you wish to update/correct a provider name, you **MUST** first follow Gainwell Technology's process to make that revision in the Medicaid Management Information System or MMIS.
- Name changes - no PCMH Change Request Form (CRF) is needed. Update the name change with Gainwell Technologies/MMIS and it will be updated for PCMH.
- An address update may be requested by submitting a letter on letterhead to Gainwell Technology's Provider Enrollment at P.O. Box 5007, Hartford, CT, 06104-5007 or by initiating that change on the Secure Web portal at www.ctdssmap.com. If the address is associated to a brand new site location, you must complete an enrollment application at www.ctdssmap.com by selecting **Provider**, then **Provider Enrollment**. Only when the address update or enrollment application for the new site location is complete should you submit the address update to CHNCT. Questions on this process can be directed to the Gainwell Technologies Provider Assistance Center at 1.800.842.8440.

- Contact your Gainwell Technologies Provider Relations Representative to discuss the process to change your Tax Identification Number (TIN) and/or any changes to your Medicaid CMAP/AVRS Number(s).One or more transactions can be made using the same form but certain changes may require the practice to complete a form for each site. For example, a practice may want to notify CHNCT that a change was made to more than one address at more than one site. This would require that you complete two separate Change Request Forms, one Change Request Form for each site's address change notification.

Electronic Submission of the Change Request Form:

1. Please read the instructions before submitting. It is important to download the file before filling it out and **to save the file before submitting the document**. Please submit using the current form on the website, as the content is periodically revised.
2. This form was created using Adobe® Acrobat® 10 Pro Version 10.1.16. It has been tested using Adobe® Acrobat® Reader 11 and Microsoft® Internet Explorer®11.0.
3. The form should be submitted using an Adobe® Acrobat® application using Internet Explorer®. The free version of Acrobat® Reader is available from Adobe® at http://get.adobe.com/reader/.
4. When the form is complete and correct, save the form as a PDF as follows: ***practicename_PCMHGlidePathChangeRequestForm_mm-dd-yyyy.pdf*.** Save and retain this form for any updates or changes to prevent lost data.
5. After this form is saved, click the SUBMIT button on the last page to transmit the data to the Medical Administrative Service Organization (ASO). You will automatically receive a **Message Received** reply with a tracking number. Save the **Message Received** reply and note the tracking number for future reference and any future additions or changes to your form.

Additions or Changes to this Change Request Form:

If any additions or changes to this Change Request Form are necessary, be sure to reference the original tracking number received after your original Change Request Form submission.

Electronic Claims Submission Reminder:

Electronically submitted claims are a requirement under the PCMH program in order to receive the appropriate differential payment. Paper claim submissions are not subject to receiving the differential payment.

II. Overview of PCMH and Glide Path Form Requirements

PCMH SECTION			INFORMATION REQUIRED
SECTION	INSTRUCTIONS (REFER TO PAGE)	FORM (REFER TO PAGE)	CONTENTS
Section A	4	10	Required Practice Site Information. All fields are required.
Section B	4	10	Notification of Practice Site Address Changes
Section C	5	11	Notification of Primary FQHC-PCMH, PCMH, or Glide Path participant Contact Changes
Section D	5	11	Notification of Practice Name Change
Section E	6	11	Glide Path Extension Request Information (Not applicable to FQHC-PCMH Participants)
Section F	6	11	Notification of Site Termination
Section G	7	12	Certification Information
Section H	8	13	Notification of Practitioners to Add or Remove
Section I	8	14	Signature
Section J	8	14	Electronic Submission

III. Detailed Description of PCMH and Glide Path Form Requirements

**** Asterisks indicate fields in Section A which are always required.***

A. NOTIFICATION OF PRACTICE SITE CHANGES		
FIELD NUMBER AND NAME		DESCRIPTION
*A.1	**Practice Name**	Enter the name of the practice that is requesting the change(s) contained in this form.
*A.2	**Practice National Provider Identifier (NPI) Number**	Enter the practice NPI number.
*A.3	**List all Connecticut Medical Assistance Program (Group CMAP) numbers for the change(s) request. (ENTER BILLING CMAP ID NUMBERS ONLY)**	Enter all applicable billing CMAP provider ID numbers for the practitioner(s) changes being requested on this PCMH and Glide Path Change Request Form. The Practice's Medicaid (Billing) CMAP/AVRS Number(s) indicated in this Section must correlate with the Medicaid (Billing) Number(s) indicated in Section G.8 for the changes requested. CMAP provider numbers are sometimes referred to as "AVRS IDs" on CMAP remittance advice. A practice may have different CMAP numbers (which may map to one or multiple NPI's) maintained for different specialties such as internal medicine, family practice, pediatrics, and nurse practitioners; all relevant billing provider numbers should be included for the changes being requested.
*A.4	**Address Line 1**	Enter the street name and number for the practice's service location/site address. This cannot be a P.O. Box.
*A.5	**Address Line 2**	Enter additional information for the practice's service location/site address. This cannot be a P.O. Box.
*A.6	**City**	Enter the city name for the practice's service location/site address.
*A.7	**State**	Enter the state name or abbreviation for the practice's service location/site address.
*A.8	**Zip Code**	Enter the 5-digit zip code for the practice's service location/site address.
*A.9	**PCMH Contact Requesting Change First Name**	Enter the first name of the contact person requesting these changes.
*A.10	**PCMH Contact Requesting Change Last name**	Enter the last name of the contact person requesting these changes.
*A.11	**PCMH Contact Requesting Change Email**	Enter the email address of the contact person requesting these changes.
*A.12	**PCMH Contact Requesting Changes Telephone Number**	Enter the telephone number of the contact person requesting these changes.

B. NOTIFICATION OF CURRENT PCMH, GLIDE PATH, OR FQHC-PCMH ACCREDITATION SERVICE LOCATION ADDRESS CHANGES		
FIELD NUMBER AND NAME		DESCRIPTION
B.1	**New Address Line 1**	Enter the street name and number of the practice's new service location/site address.
B.2	**New Address Line 2**	Enter additional information for the practice's new service location/site address.
B.3	**New Practice City**	Enter the city name for the practice's new service location/site address.
B.4	**New Practice State**	Enter the state name or abbreviation for the practice's new service location/site address.

B.5	**New Practice Zip Code**	Enter the 5-digit zip code for the practice's new service location/site address.
B.6	**New Address Start Date**	Enter the start date (mm/dd/yyyy) of the service location/site address.
B.7	**Previous Address End Date**	Enter the end date (mm/dd/yyyy) of the previous service location/site address.
B.8	**New Practice Telephone number**	Enter the telephone number for the practice's new service location/site.
B.9	**Previous Telephone Number**	Enter the telephone number for the practice's previous service location/site.
B.10	**New Practice Fax Number**	Enter the fax number for the practice's new service location/site.
B.11	**Previous Fax Number**	Enter the fax number for the practice's previous service location/site.

C. Notification of Primary PCMH, Glide Path, or FQHC-PCMH Accreditation Contact Changes

FIELD NUMBER AND NAME		DESCRIPTION
C.1	**Change to Primary PCMH Contact First Name**	Enter the first name of the new primary PCMH contact (e.g., the lead individual for the PCMH initiative) responsible for initiating these PCMH or Glide Path changes.
C.2	**Change to Primary PCMH contact Last Name**	Enter the last name of the new primary PCMH contact.
C.3	**Change to Primary PCMH Contact Email**	Enter the email address for the new primary PCMH contact.
C.4	**Change to Primary PCMH Contact Address Line 1**	Enter the street name and number for the new primary PCMH contact. This cannot be a P.O. Box.
C.5	**Change to Primary PCMH Contact Address Line 2**	Enter the additional information for the new primary PCMH contact. This cannot be a P.O. Box.
C.6	**Change to Primary PCMH Contact City**	Enter the city name for the new primary PCMH contact.
C.7	**Change to Primary PCMH Contact State**	Enter the state name or abbreviation of the state for the new primary PCMH contact.
C.8	**Change to Primary PCMH Contact Zip Code**	Enter the 5-digit zip code for the new primary PCMH contact.
C.9	**Change to Primary PCMH Contact Telephone Number**	Enter the telephone number for the new primary PCMH contact.

D. Notification of Practice Name Change

FIELD NUMBER AND REQUIRED INFORMATION		DESCRIPTION
D.1	**Practice Name Prior to Change**	Enter the practice's previous name.
D.2	**Practice Name**	Enter practice's current name.
D.3	**Practice Name Effective Date**	Enter the date (mm/dd/yyyy) of the practice name change. This date must be consistent with the effective date used by Gainwell Technologies.
D.4	**Practice Name Change Reason**	Enter reason for practice name change.

E.	GLIDE PATH EXTENSION REQUEST INFORMATION (NOT APPLICABLE TO FQHC-PCMH ACCREDITATION PRACTICES)	
FIELD NUMBER AND REQUIRED INFORMATION		DESCRIPTION
E.1	**The practice may request one or more extensions; the combined duration of such extensions, however, may not exceed six months. Practices must complete the entire Glide Path in no more than 24 months, including any requested extensions.**	Select the box of the Phase being extended Phase 1 Phase 2 Phase 3
E.2	**Indicate Total Number of Months Requested**	Enter the total number of months requested.
E.3	**Indicate Requested New Phase Completion Date**	Enter the new completion date requested to complete the phase requirements.

F.	NOTIFICATION OF SITE TERMINATION	
FIELD NUMBER AND REQUIRED INFORMATION		DESCRIPTION
F.1	**End Date of Participation in DSS PCMH Program**	Enter the date of the site's participation. For merged/acquired sites, this would be the day before the merger/acquisition date.
F.2	**Reason for Termination**	Select the reason from the following list (choose only one): • Did not renew NCQA PCMH recognition • No longer enrolled in CT Medicaid Program • Voluntary Termination (no longer wish to participate in CT DSS PCMH program) • Merged with/Acquired by another practice • Involuntary Termination • Other (Please specify): Enter the reason in the text box.
F.3	**Should all providers associated with the site being terminated also be terminated?**	If any one of the providers associated with the site being termed is associated with any other site in the practice, please check NO; otherwise check YES.
F.4 THROUGH F.6 ONLY TO BE COMPLETED BY SITES MERGING WITH OR BEING ACQUIRED BY ANOTHER PRACTICE.		
F.4	**Previous Practice Federal Tax Identification Number (TIN)**	Enter the TIN of the practice site being termed.
F.5	**New Practice Name**	Enter the name of the practice acquiring or merging with the site. Please note that a new PCMH application needs to be completed to enroll the site under the new practice.
F.6	**New Practice Federal Tax Identification Number (TIN)**	Enter the TIN of the practice acquiring or merging with the site.

G. CERTIFICATION/RECOGNITION INFORMATION		
FIELD NUMBER AND REQUIRED INFORMATION		DESCRIPTION
G.1	**New National Committee for Quality Assurance (NCQA) PCMH Level Recognition**	Enter all information requested to change the practice's NCQA Recognition or Standard Level. Indicate the following: ▪ Select applicable recognition status change ▪ Check applicable recognition year change ▪ Enter new recognition effective date/anniversary date ▪ Enter new recognition end date (2014 Standards only)
G.2	**New Ambulatory Accreditation and/or Primary Care Medical Home certification by The Joint Commission**	Enter all the information requested to change the practice's accreditation and/or PCMH certification status. Indicate the following: ▪ Change in status; check appropriate box ▪ Enter PCMH certification effective date

IV. Important Information for Completing Section H

a. When adding a practitioner to a FQHC-PCMH, PCMH, or Glide Path participant practice, please complete all fields in Section H with the exception of the practitioner's end date. Practices utilizing Community Preceptors may add them as eligible practitioners by selecting "No-Community Preceptor" in Section H.13.

   Please note that a provider should be added to the practice as soon as possible after enrollment in the CMAP program in order to begin receiving the PCMH enhanced rate.

   Retroactive processing of claims will go back no further than the first of the month that is 60 days prior to receipt of the Change Request form, or the CMAP effective date of the provider, which ever date is later.

b. All eligible practitioners must function as PCPs and must account for at least 60% of their time in providing primary care services. Physicians (MD or DO) must have a panel of primary care patients or a patient panel. The only exception to having a panel of primary care patients is for a Community Preceptor(s). Community Preceptor means a physician who supervises one or more residents who provide care to patients at a practice other than the community preceptor's primary practice (not applicable to FQHC-PCMH participants).

c. Specialists or other practitioners who do not have their own patient panels are not eligible for PCMH participation, except for PAs and APRNs that are enrolled and bill under their APRN CMAP number, otherwise they are not eligible to participate in PCMH. APRNs that do not practice independently and are billing for services under the MD provider number with modifier SA, are not eligible to participate in PCMH and should not be listed on this form (not applicable to FQHC-PCMH accreditation participants).

d. To remove a practitioner from a FQHC-PCMH, PCMH, or Glide Path participant practice, please fill-in the practitioner name, practitioner NPI and CMAP numbers, and the practitioner's end date in Section H.

H. Notification of Practitioners to Add or Remove

PLEASE REFER TO INFORMATION ON PREVIOUS PAGE BEFORE FILLING OUT THIS PORTION OF THE FORM

FIELD NUMBER AND REQUIRED INFORMATION		DESCRIPTION
H.1	**Practitioner Change Type**	Select if each practitioner listed in Section H is being added or removed.
H.2	**Practitioner First Name**	Enter first name of each practitioner to be added or removed.
H.3	**Practitioner Middle Initial**	Enter middle initial of each practitioner to be added or removed.
H.4	**Practitioner Last Name**	Enter last name of each practitioner to be added or removed.
H.5	**Practitioner Credential**	Enter each practitioner's credential. Indicate whether the practitioner is an MD, DO, APRN, or PA.
H.6	**Practitioner Area of Service**	Select the area of service (Internal Medicine, Family Medicine, Pediatrics, or Geriatrics). Area of service refers to specialty or area in which the practitioner functions. Primary Care Provider specialties of Family Medicine, Internal Medicine, Pediatrics, and Geriatric Medicine are eligible to be added to a FQHC-PCMH, PCMH, or Glide Path participant Practice.
H.7	**Practice Medicaid Group (CMAP/AVRS) Billing Number**	Enter the practice's Medicaid (CMAP/AVRS) number.
H.8	**Practitioner National Provider Identifier (NPI) Number**	Enter each practitioner's NPI number.
H.9	**Practitioner Medicaid (CMAP/AVRS) Number**	Enter each practitioner's Medicaid (CMAP/AVRS) number.
H.10	**Practitioner Start Date**	Enter each practitioner's start date to add a practitioner(s). The start date refers to the effective date the practitioner joined your practice. This date must be greater than or equal to the date in which your practice became effective as a PCMH or Glide Path practice. Start date is required only when adding practitioners to your practice.
H.11	**Practitioner End Date**	Enter each practitioner's end date to remove a practitioner. End date is required only when removing practitioners from your practice.
H.12	**Indicate if each practitioner manages a panel of primary care patients by selecting "YES" or "NO" or "No-Community Preceptor." "Community Preceptor" is a physician who supervises one or more residents who provide care to patients at a practice other than the community preceptor's primary practice (not applicable to FQHC-PCMH participants).**	
H.13	**Indicate if at least 60% of each practitioner's clinical hours are spent providing primary care services across all payers by selecting "YES" or "NO" (not applicable to FQHC-PCMH participants).**	

I. Signature

An individual authorized to act as a signatory for the practice must sign the form.
In doing so, the signatory certifies that all information provided in the form is accurate.
By clicking the "I agree" box and typing your name, you are signing this form electronically.
You agree your electronic signature is the legal equivalent of your manual signature on the agreement.

J. Electronic Submission

IMPORTANT: SAVE THIS FORM! While editing the PCMH CHANGE REQUEST FORM and when it is completed, save this form using the convention ***practicename_PCMHGlidePathChangeRequestForm_mm-dd-yyyy.pdf*.**

-- ANY DATA NOT SAVED WILL BE LOST --

By clicking the **SUBMIT** button at the bottom of this document, and **after saving this form**, you certify that all information provided in the form is accurate and correct.
Clicking the SUBMIT button transmits the information to the PCMH Program Administrator.

Person-Centered Medical Home
PCMH & Glide Path Change Request Form

Revision E – March 12, 2018

PCMH and GLIDE PATH CHANGE REQUEST FORM

A. REQUIRED INFORMATION

FIELD NUMBER AND REQUIRED INFORMATION		PRACTICE RESPONSE	
*** Asterisk fields MUST be completed regardless of additional sections completed.**			
*A.1	**Practice Name**		
*A.2	**Practice National Provider Identifier (NPI) Number**		
*A.3	**List all Connecticut Medical Assistance Program (Group CMAP) numbers for the change(s) requested. (ENTER BILLING CMAP ID NUMBERS ONLY)**	1.	
		2.	
		3.	
		4.	
		5.	
		6.	
*A.4	**Address Line 1**		
*A.5	**Address Line 2**		
*A.6	**City**		
*A.7	**State**		
*A.8	**Zip Code**		
A.9	**PCMH Contact Requesting Change First Name**		
A.10	**PCMH Contact Requesting Change Last Name**		
A.11	**PCMH Contact Requesting Change Email**		
A.12	**Primary PCMH Contact Requesting Change Telephone Number**	EXT	

B. NOTIFICATION OF PRACTICE ADDRESS CHANGES

FIELD NUMBER AND REQUIRED INFORMATION		PRACTICE RESPONSE
B.1	**New Address Line 1**	
B.2	**New Address Line 2**	
B.3	**New Practice City**	
B.4	**New Practice State**	
B.5	**New Practice Zip Code**	
B.6	**New Address Start Date (mm/dd/yyyy)**	
B.7	**Previous Address End Date (mm/dd/yyyy)**	
B.8	**New Practice Telephone Number**	
B.9	**Previous Telephone Number**	
B.10	**New Practice Fax Number**	
B.11	**Previous Fax Number**	

C. Notification of Primary PCMH, Glide Path, or FQHC-PCMH Accreditation Contact Changes

FIELD NUMBER AND REQUIRED INFORMATION		DESCRIPTION
C.1	**Primary PCMH Contact First Name**	
C.2	**Primary PCMH Contact Last Name**	
C.3	**Primary PCMH Contact Email**	
C.4	**Primary PCMH Contact Address Line 1**	
C.5	**Primary PCMH Contact Address Line 2**	
C.6	**Primary PCMH Contact City**	
C.7	**Primary PCMH Contact State**	
C.8	**Primary PCMH Contact Zip Code**	
C.9	**Primary PCMH Contact Telephone Number**	EXT

D. Notification of Practice Name Change

FIELD NUMBER AND REQUIRED INFORMATION		DESCRIPTION
D.1	**Practice Name Prior to Change**	
D.2	**Practice Name**	
D.3	**Practice Name Effective Date (mm/dd/yyyy)**	
D.4	**Practice Name Change Reason**	

E. Glide Path Extension Request Information (Not Applicable to FQHC-PCMH Accreditation)

FIELD NUMBER AND REQUIRED INFORMATION		PRACTICE RESPONSE
E.1	**Indicate Phase Extension Request**	☐ Phase 1 ☐ Phase 2 ☐ Phase 3
E.2	**Total Months Requested**	
E.3	**New Phase Completion Date (mm/dd/yyyy)**	

F. Notification of Site Termination

FIELD NUMBER AND REQUIRED INFORMATION		DESCRIPTION
F.1	**End Date of Participation in DSS PCMH Program (mm/dd/yyyy)**	
F.2	**Reason for Termination**	☐ Did not renew NCQA PCMH recognition ☐ No longer enrolled in CT Medicaid Program ☐ Voluntary Termination (no longer wish to participate in CT DSS PCMH program) ☐ Merged with/Acquired by another practice ☐ Involuntary Termination ☐ Other (Please specify):

F.3	**Should all providers associated with the site being terminated be removed from the practice's PCMH roster?**	☐ Yes ☐ No
F.4 THROUGH F.6 ONLY TO BE COMPLETED BY SITES MERGING WITH OR BEING ACQUIRED BY ANOTHER PRACTICE. Note: A DSS PCMH Application must be submitted to enroll the site under the new practice		
F.4	**Previous Practice Federal Tax Identification Number (TIN)**	
F.5	**New Practice Name**	
F.6	**New Practice Federal Tax Identification Number (TIN)**	

G. CERTIFICATION/RECOGNITION INFORMATION

FIELD NUMBER AND REQUIRED INFORMATION		PRACTICE RESPONSE	
		RECOGNITION STATUS	**RECOGNITION YEAR CHANGE**
G.1	**National Committee for Quality Assurance (NCQA) PCMH Recognition Change**	Select...	☐ 2014 Standards ◯ Level 1 ◯ Level 2 ◯ Level 3 **NEW EFFECTIVE DATE (MM/DD/YYYY)** / **NEW END DATE (MM/DD/YYYY)** ☐ 2017 Standards Distinction Modules ☐ BHI ☐ eCQM Reporting ☐ Patient Experience Reporting ☐ No Distinction Module **NEW EFFECTIVE DATE: (MM/DD/YYYY)**
G.2	**The Joint Commission (TJC) Ambulatory Care Accreditation/Primary Care Medical Home Certification Change**	**ACCREDITATION STATUS** Select...	**NEW EFFECTIVE DATE (MM/DD/YYYY)**

CONNECTICUT MEDICAL ASSISTANCE PROGRAM
PCMH and Glide Path Change Request Form

H. NOTIFICATION OF PROVIDERS TO ADD OR REMOVE

	1	2	3	4	5	6	7	8	9	10	11	12	13
	PRACTITIONER CHANGE TYPE	PRACTITIONER FIRST NAME	M.I.	PRACTITIONER LAST NAME	PRACTITIONER CREDENTIAL	PRACTITIONER'S AREA OF SERVICE	PRACTICE GROUP MEDICAID (CMAP/AVRS) BILLING NUMBER	PRACTITIONER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	PRACTITIONER MEDICAID (CMAP/AVRS) NUMBER	PRACTITIONER EFFECTIVE DATE (MMDDYYYY)	PRACTITIONER END DATE (MMDDYYYY)	DOES THE PRACTITIONER MANAGE A PANEL OF PRIMARY CARE PATIENTS? (NOT APPLICABLE TO FQHC-PCMH PARTICIPANTS)	ARE AT LEAST 60% OF THE PRACTITIONER'S CLINICAL HOURS SPENT PROVIDING PRIMARY CARE SERVICES TO A PANEL OF PATIENTS? (NOT APPLICABLE TO FQHC-PCMH PARTICIPANTS)
	ADD REMOVE											SELECT YES, NO, OR, NO - COMMUNITY PRECEPTOR	SELECT YES OR NO
1													
2													
3													
4													
5													
6													
7													
8													
9													
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11													
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18													
19													
20													

NOTE: Please list APRNs and PAs who do not have their own panel of patients.

I. SIGNATURE

THE INFORMATION PROVIDED IN THIS PCMH AND GLIDE PATH CHANGE REQUEST FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AS AN INDIVIDUAL AUTHORIZED BY THE PRACTICE TO MAKE PCMH AND GLIDE PATH CHANGES BASED ON THE SUBMISSION OF THIS FORM.

An individual authorized to act as a signatory for the practice must also provide an electronic signature on the form. In doing so, the signatory certifies that all information provided in the form is accurate. Direct any questions regarding the FQHC-PCMH Participant and PCMH Change Request process to the PCMH Program Administrator at 203.949.4124 or by email at pcmhapplication@chnct.org.

Provider Entity Name (doing business as)

**Name of Representative Authorized to Request these Changes*

Electronic Signature Agreement. By clicking "I agree" and typing your name below, you are signing this form electronically. You agree your electronic signature is the legal equivalent of your manual signature on this document.

☐ **I agree**

Signature *Date (mm/dd/yyyy)*

Internal Use Only for Community Practice Transformation Specialists to Authorize a Glide Path Extension change, Glide Path End Date change, and other changes as required.

Electronic Signature Agreement. By clicking "I agree" and typing your name below, you are signing this form electronically. You agree your electronic signature is the legal equivalent of your manual signature on this document.

☐ **I agree**

Signature *Date (mm/dd/yyyy)*

J. ELECTRONIC SUBMISSION

IMPORTANT: Please read the instructions before submitting.
It is important to download the file before completing and saving the file before submitting the document.
Please submit using the current form on the website, as the content is periodically revised.
This form was created using Adobe® Acrobat® 10 Pro Version 10.1.16.
It has been tested using Adobe® Acrobat® Reader 11 and Microsoft® Internet Explorer® 11.0
The form should be submitted using an Adobe® Acrobat® application using Internet Explorer®.
The free version of Acrobat® Reader is available from Adobe® at http://get.adobe.com/reader/.
SAVE THIS FORM! While editing the PCMH CHANGE REQUEST FORM and when it is completed, save this form using the convention practicename_PCMHGlidePathChangeRequestForm_mm-dd-yyyy.pdf.
-- ANY DATA NOT SAVED WILL BE LOST --
By clicking the **SUBMIT** button at the bottom of this document, and **after saving this form**, you certify that all information provided in the form is accurate and correct.
Click SUBMIT to send the completed form to the Department's Medical ASO.

SUBMIT

If you have any questions about this PCMH Glide Path form, contact the Medical ASO at 203.949.4194 or pcmhglideapplication@chnct.org.