PHYSICIAN CONFIRMATION FORM

For Reductions or Discontinuances of Services
Within the AIDS Home Care Program (AHCP)

Patient's Name: _____ **Date:** _____

Date of Birth: _____ **Physician's Name:** _____

CIN#: _____ **Physician's Fax Number:** _____

A Medicaid recipient may request a State fair hearing when a social services district or a AIDS Home Health Care Program (AHCP) proposes to reduce or discontinue a service the Medicaid recipient receives within the AHCP and the recipient's treating physician disagrees with the proposed reduction or discontinuance of the service.

We are proposing to reduce or discontinue one or more services your patient receives within the AHCP. We must know whether you agree with this proposed change. (We are NOT proposing to discontinue your patient's participation in the AHCP itself.)

We are proposing that _____ be changed as follows:
(insert name of service)

FROM: _____

_____

_____

TO: _____

_____

_____

BECAUSE: _____

_____

PLEASE INDICATE WHETHER YOU AGREE WITH THIS PROPOSED CHANGE:

☐ I **AGREE** with this proposed change.

☐ I **DISAGREE** with this proposed change BECAUSE (optional)

_____

_____

_____

PLEASE RETURN THIS FORM WITHIN 10 BUSINESS DAYS TO:

_____

_____

_____

TELEPHONE NO: _____ FAX NO: _____

_____ _____

Physician's Signature Date