NC MCO PARTICIPANT/EMPLOYER INFORMATION & REFERRAL FORM

Acumen Fiscal Agent
Innovation · Opportunity · Freedom

Participant Information

Participant Name: _____

Medicaid Number: _____ **DOB:** _____ **AGE:**_____

MCO: _____ **MCO Record #:** _____

SS#: _____ **Gender:** _____ **Language:** _____ **Race:** _____

Home Address: _____

Mailing Address: _____

Home Phone: _____ **Cell #:** _____

Email Address: _____

Legal Guardian Information (If Applicable)

Is the Participant an Adult 18 years or over? Yes____ No_____ If yes, are they their own legal guardian? Yes____ No____ If no, fill out the section below.

Guardian Name: _____

Home Address: _____

Mailing Address: _____

Home Phone: _____ **Cell #:** _____

Email Address: _____

Employer (EOR) Information – *Who can be the EOR? Per Clinical coverage Policy 8P, the Participant (if they are their own legal guardian), the Guardian, (if the participant has been deemed incompetent by the court). A Non-Guardian cannot be the EOR. The participant or a guardian can delegate a representative to assist them the employer duties.*

Name: _____ **Social Security #:**_____ **DOB:**_____

Home Address: _____

Mailing Address: _____

Phone Number: _____ **Email:** _____

Do you have a FEIN, in your name? Yes____ No ____ If so, the FEIN number is: _____

Care Manager Information

Care Manager Name: _____ **Email:** _____ **Phone:** _____

Care Manager Agency: _____

Community Navigator Information

Community Navigator Name: _____ **Email:** _____ **Phone:** _____

Community Navigator Agency: _____

Please send completed form to ncmcoagents@acumen2.net