Form 3591
August 2014-E

CLASS IPC/IDRC Cover Sheet

To:

HHSC — CLASS Waiver Program
Mail Code W-521
P.O. Box 149030
Austin, TX 78714-9030

From:

Name of Agency: ____________________
Agency Vendor Number: ____________________
Name of CM/DSA Representative: ____________________
Phone Number: ____________________
Fax Number: ____________________

Name of Individual	Medicaid Number	Submission Date

☐ **IPC Submission** Effective Date: ____________

☐ Enrollment ☐ Revision ☐ Renewal ☐ Transfer ☐ Termination

☐ Response to Remand ATTN: ____________________

☐ **ID/RC Submission** Effective Date: ____________

Purpose Code: ☐ 2 (Enrollment) ☐ 3 (Renewal) ☐ E (Gap)

☐ Response to Remand ATTN: ____________________

For State Office Use Only

Reviewer: ☐ AH ☐ CM ☐ DB ☐ ED ☐ JM ☐ KH ☐ MSB ☐ PK ☐ Other: ____________

Date HHSC Received: ____________

HHSC Assigned Date: ____________

Date Sent to Program Enrollment/Utilization Review Nurse: ____________
(Only if indicated by services requested)

Review Outcome: ☐ ____________ Authorized ☐ Remanded ☐ Denied/Reduced

☐ Other: ____________________

Review Completed Date: ____________