Department of Health & Human Services
DHHS
NEBRASKA

Division of Medicaid and Long-Term Care

Client Choice of Restricted Services (Lock-In) Provider Agreement

(1) Client Name	Office Use Only REQUIRED CATEGORY	(6)
(2) Medicaid ID Number	(7) CODE/CATEGORY	
(3) Address	1 One Pharmacy 2 One Pharmacy and One Prescribing Provider 3. One Pharmacy, One Prescribing Provider and One Hospital 9 All Medical Services	
Phone Number		
(4) City or Town		
(5) Managed Care Plan Name		

(8)	(9)
☐ Pharmacy	Name Address
☐ Prescribing Provider MD, DO & APRN Only	Name Provider ID # Address
☐ Hospital (Does not apply to Inpatient Hospital Services)	Name Address
☐ Secondary Prescribing Provider	Name Address

If you are enrolled in a Physical Health Managed Care Plan your Restricted Services Prescribing Provider must be your Primary Care Provider (PCP) in your Managed Care Plan.

I do hereby select the above Providers that I listed as my choice of medical providers.

I understand that, as of this date, any medical services provided by providers other than the above will be my own personal financial responsibility.

☐ Signed ______________________________
(10)

☐ Witness ______________________________
(11)

☐ Date ______________________________
(12)

☐ New Restricted Service Client ____________ Yes / No (circle one) ____________
(13)

☐ Reason for Change ______________________________
(14)

☐ Change of Provider(s) Effective Date: ______________________
(15)

RESTRICTED SERVICES INSTRUCTIONS

Item 1-5 Information may be entered by the Client, Department personnel, Enrollment Broker personnel or a health care provider

Item 6, 7 Required category will be determined by the State Advisory Drug Utilization Review Board for Medicaid recipient and by Managed Care Plan for Medicaid Managed Care members.

Item 7

Code	Category
1	One Pharmacy You must select one pharmacy. The Department will approve payment for prescriptions only to the pharmacy you select.
2	One Pharmacy and One Prescribing Provider. You must select one pharmacy and one Prescribing Provider. The Department will approve payment to the pharmacy and Prescribing Provider you select.
3	One Pharmacy, One Prescribing Provider, and One Hospital.
9	All Medical Services You must select one provider for each type of service you expect to receive. All types of medical services are included and the Department will approve payment only to the providers you select.

Item 8 The State Advisory Drug Utilization Review Board and/or your Managed Care Plan will determine the type of provider(s) to be selected, and will be completed by Department personnel; Enrollment Broker, or your Managed Care Plan personnel.

Item 9 Name and Address of Provider(s) selected by the Client may be entered by the Client, Department personnel, Enrollment Broker personnel, or a health care provider.
For Client, the Provider ID# is optional.

Item 10 Client **must** sign the agreement.

Item 11 The person that witnesses the Client's signature **must** sign. The witness **must** verify the Client's identity.

Item 12 Date of signing may be completed by either the Client or the Witness.

Item 13, 14 May be completed by the Client, Department personnel, Enrollment Broker or health care provider.

Item 15 Changes will be effective the day this completed Client Choice of Restricted Services Provider Agreement form is returned to the following:

If you are a new or current Medicaid Client, and need assistance completing this form, please contact the Medicaid and Long-Term Care, Pharmacy Unit, (877) 255-3092, Option 3.
Please Fax the completed the form to:
Fax: (402) 742-2348