

**WRIGHT COUNTY HUMAN SERVICES AGENCY
HEALTH CARE ACCESS SERVICES**

Letter of Intent to Relocate

Instructions to MA Recipient: You are seeking prior authorization for reimbursement of transportation/travel costs related to Health Care Access Service. Since you have also expressed that your current Primary Health Care Provider is located outside of your town/city of residence zip code, you do have the option of relocating your Primary Health Care Provider to a location within your residence zip code. **Please complete the following information:**

Date of Form Submission: _____

Full Legal Name: _____

DOB: _____

MA (MAXIS) #: _____

Physical Address: _____
Street Address / City / State / ZIP Code

Select one of the choices below:

My current Primary Health Care Provider is located outside of the zip code listed above. I will seek a Letter of Medical Necessity from this provider, which will explain why the care required for my condition cannot be sought from any closer provider to my home residence. I understand this letter must be provided to WCHS before prior authorization for service reimbursement may be obtained.

My current Primary Health Care Provider is located outside of the zip code listed above. Although I know there are providers located closer to my home address, I choose to retain this current health care provider as my personal choice. I understand by selecting this choice, I am not eligible to receive reimbursement for transportation/ travel related costs under the Health Care Access Program.

My current Primary Health Care Provider is located outside of the zip code listed above, and I am currently in the process of seeking out a Health Care Provider located within my residence zip code, so that I may complete the prior authorization process for Health Care Access Services. I understand I have **10 calendar days** from the date of this form submission to complete this relocation process and notify Wright County Human Services who my new primary care provider will be.

If there are other conditions/circumstances related to the location of your current health care provider, please note this information below:

By signing below, I verify the above information is accurate.

DATE: _____
MA Recipient's Signature

Please mail, FAX or email a copy of this signed form to:

Wright County Human Service Agency

Attn: Health Care Transportation

1004 Commercial Drive, Buffalo MN 55313

FAX: 763-682-7701 (Attn: Health Care Transportation Liaison)

Email: Ann.Rassat@co.wright.mn.us

(Photocopied signatures of this form will be accepted.)

For additional inquiries Phone: 763-682-7482 or Toll Free: 1-800-362-3667, ext. 7482