



DATE OF DIAGNOSIS: STATE ID:

SPECIAL CAPITATION ENROLLEE

Notification from MCO of HIV Positive Enrollee

(Pediatric – Patients less than 13 years of age at time of diagnosis, excluding newborns)

On the basis of the best available medical evidence, the following member (less than 13 years old) has been diagnosed as being HIV+

Effective Date of Enrollment:

MCO

Name: Last First MI

Address: Street Apt.

City State Zip

Resident County: Medical Assistance Number:

Birth Date: Gender: M F

Race: (check all that apply) White African American Hispanic Asian/Pacific Islander Native American/American Indian Other: (define)

Social Security Number:

PCP: Phone Number of PCP:

Date Submitted by MCO:

For Recipients less than 13 years of age at the time of diagnosis (excluding Newborns): Birth Hospital: Mother's Name: Mother's MA No.: Mother's Social Security No.: Mother's Date of Birth:

Please mail results of laboratory testing to support verification to: IDEHA/CHSE, 500 North Calvert Street, 5th Floor, Baltimore, MD 21202 Attn: MCO Coordinator

Forward completed Capitation form to: DHMH HealthChoice Enrollment Unit, 201 W. Preston Street, Room L-9 Baltimore, MD 21201 Attention: Rosemary Vranish

TO BE COMPLETED BY DHMH:

Diagnosis Verified: Date Received by DHMH:

Confirmed Spans: Date Received by IDEHA/CHSE: