New Jersey Department of Human Services

**Division of Developmental Disabilities**

**Support Coordination Agency – ISP Retroactive Change Request (RCR) Form**

**Directions for SCA:**

1. The SC completes this RCR Form including all required information.
2. The SC reviews request with Provider, confirms information and has Provider sign that they agree to content.
3. The SC ensures that the Provider understands that they should not bill for time frame in question until resolved.
4. SC Supervisor uploads a copy of this request form (with all signatures) to I record.
5. SC Supervisor emails **DDD ISP Retroactive Changes (DDD.ISPRetroactiveChanges@dhs.state.nj.us)** using Subject line: **<Name of SCA> – <DDD ID#>** to alert that RCR has been uploaded. **DO NOT ATTACH THE RCR TO THIS EMAIL.**

|  |  |
| --- | --- |
| **SCA:** | **Date of Request:** |
| **SCS:** | **Provider (of service needing change):** |
| **S SC:** | **SCA’s QAS:** |

**THE CHANGE BEING REQUESTED:**

**Service Date modification** **Incorrect Service Type** **Service not listed**

**Unit Modification** **Incorrect Rate** **Other**

**Inaccurate Provider Information**

**Detailed reason for current error (200 character maximum)**:

**REQUIRED INFORMATION:**

**Request #1**

**Participant ID**

**Plan ID**

**Outcome Number**

**Service number**

**Service Start Date**

**Service End Date**

**Total number of units to be:** (Insert number next to correct command)

**Added**

**Removed**

**Total Cost**

**Exception Week Unit Distribution/Unit Breakdown**

|  |  |
| --- | --- |
| **Service Week Range** | **Total Units** |
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**Any other necessary service details**

**Request #2 (If appliable)**

**Participant ID       Must be same as Request #1**

**Plan ID       Must be same as Request #1**

**Outcome Number**

**Service number**

**Service Start Date**

**Service End Date**

**Total number of units to be:** (Insert number next to correct command)

**Added**

**Removed**

**Total Cost**

**Exception Week Unit Distribution/Unit Breakdown**

|  |  |
| --- | --- |
| **Service Week Range** | **Total Units** |
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**Any other necessary service details**

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**Provider signature to ensure above information is correct:**

**Provider signature confirming their understanding that billing on pre-authorizations for this individual for the dates above should not occur until corrections in I record are complete:**

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For internal use only: Request Approved Request Denied

Request is being sent to DDD IT  DDD IT ticket Number

Responsible for error: SCA Provider I Record Other