

**Department of Health and Human Services
RECIPIENT CHOICE OF LOCK-IN PROVIDER AGREEMENT**



(1) Recipient name	REQUIRED CATEGORY		(6)
(2) Recipient ID Number	(7) CODE	CATEGORY	
(3) Address	1	One Pharmacy	
(4) City or Town	2	One Pharmacy and One Primary Physician	
State	3	One Pharmacy, One Primary Physician and One Hospital	
Zip Code	4	One Pharmacy and One Prescribing Physician	
(5) Local Office	9	All Medical Services	

I, _____ Recipient ID Number _____
(8) (9)

do hereby select the following as my choice of medical provider(s):
(Select **only** those indicated)

(10) <input type="checkbox"/> Pharmacy	(11) Name _____ Address _____
<input type="checkbox"/> Primary Physician	Name _____ Address _____
<input type="checkbox"/> Hospital	Name _____ Address _____
<input type="checkbox"/> Prescribing Physician	Name _____ Address _____

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 _____
(12)

Witnessed _____
(13)

Date _____
(14)

- Original Selection (15)
 Change of Provider(s) Effective Date: _____

Reason for change: _____
(16)

- Item 1-5,8,9 Information may be entered by the Recipient, Department personnel, Nebraska Health Connection personnel or a health care provider
- Item 6,7 Required category will be determined by the State Utilization Review Committee, but will be completed by Department personnel.
- 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 Primary Physician |
| | You must select one pharmacy and one primary physician. The Department will approve payment to the pharmacy and primary physician you select. |
| 3 | One Pharmacy, One Primary Physician, and One Hospital |
| | You must select one pharmacy, one primary physician and one hospital. The Department will approve payment only to the pharmacy, primary physician, and hospital you select. |
| 4 | One Pharmacy and One Prescribing Physician |
| | You must select one pharmacy and one prescribing physician. The Department will approve payment for prescriptions only to the pharmacy you select. You may visit other physicians, but all prescriptions must be authorized by the prescribing physician you select. |
| 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 10 The State Utilization Review Committee will determine the type of provider(s) to be selected, but will be completed by Department personnel.
- Item 11 Name and Address of Provider(s) selected by the Recipient may be entered by the Recipient, Department personnel, Nebraska Health Connection personnel or a health care provider
- Item 12 Recipient **must** sign the agreement.
- Item 13 The person that witnesses the recipient's signature **must** sign. The witness **must** verify the Recipients identity.
- Item 14 Date of signing may be completed by either the Recipient or the Witness
- Item 15,16 May be completed by the Recipient, Department personnel, Nebraska Health Connection personnel or health care provider.
- Item 16 Changes will be effective the first day of the following month, unless a different date is requested, the reason is documented and the date is approved by the Utilization Review Committee.