TEXAS Health and Human Services

**Form 3591**
August 2014-E

# CLASS IPC/IDRC Cover Sheet

**To:**

DADS — CLASS Waiver Program
Mail Code W-521
P.O. Box 149030
Austin, TX 78714-9030

**From:**

Name of Agency: _____

Agency Vendor Number: _____

Name of CM/DSA Representative: _____

Phone Number: _____

Fax Number: _____

| Name of Individual | Medicaid Number | Submission Date |
|---|---|---|
| | | |

☐ **IPC Submission** Effective Date: _____

☐ Enrollment ☐ Revision ☐ Renewal ☐ Transfer ☐ Termination

☐ Response to Remand ATTN: _____

☐ **ID/RC Submission** Effective Date: _____

Purpose Code: ☐ 2 (Enrollment) ☐ 3 (Renewal) ☐ E (Gap)

☐ Response to Remand ATTN: _____

**For State Office Use Only**

**Reviewer:** ☐ AH ☐ CM ☐ DB ☐ ED ☐ JM ☐ KH ☐ MSB ☐ PK ☐ Other: _____

Date DADS Received: _____

DADS Assigned Date: _____

Date Sent to Program Enrollment/Utilization Review Nurse: _____
(Only if indicated by services requested)

Review Outcome: ☐ _____ Authorized ☐ Remanded ☐ Denied/Reduced

☐ Other: _____

Review Completed Date: _____