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# FAX

# PROVIDER Notification

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| Date: |  |  |  |
| To: |  | From: | **, CC** |
| COMPANY: |  | COMPANY: |       |
| Fax: |  | Fax: |  |
| Phone: |  | Phone: |  |
| Subject: | **Support Plan** EMAIL: |

MESSAGE:

* Attached is this member’s most recent UCare Support Plan that addresses the following areas:
	+ Member’s interdisciplinary care team
	+ Member’s wishes / what is important
	+ Person-centered goals
	+ Supports and services the member chooses

Patient/Client Name**:** DOB:Health Plan ID

<Member Name>, is enrolled in UCare MSHO. As this member’s care coordinator, I facilitate communication and coordinate care across providers and settings. I am available to provide health education, assistance accessing supports and services and to assist members with optimizing health care use to improve health outcomes.

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| **Comments:**       |

I can be reached at the email address or phone number listed above should you have any questions. I look forward to working with you and <Member Name>to help facilitate smooth transitions and ensure health and safety needs are met.

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