Elderly Waiver DTR Notification
Care Coordinator Use Only

FYI ***Incomplete, illegible or inaccurate forms will be returned to sender.*** Please complete the entire form. Allow 14 calendar days for processing of this request.

Fax form and any relevant documentation to: **612-884-2185** or **1-866-402-5018**

For questions, **call: 612-676-6705**
Email: **CLSintake@ucare.org**

MEMBER INFORMATION

Member Name ____________________ Member ID ____________________

Member Address ____________________ PMI ____________________

Member City, State, Zip ____________________ Date of Birth ____________________

Member Phone ____________________ Gender: ☐ Female ☐ Male

CC INFO

Care Coordinator Name ____________________ Phone Number ____________________

Care Coordinator Email ____________________ Fax ____________________

ATTENDING HEALTH CARE PROFESSIONAL INFO

Clinician Name ____________________

Clinic Name ____________________ NPI ____________________

Clinic Address ____________________

Clinic City, State, Zip ____________________

Clinic Phone ____________________ Fax ____________________

Form must be completed by a UCare Delegated Care Coordinator.

NEW OR CURRENT EW DATE SPAN ____________________ TO ____________________

SERVICES/PROCEDURES/ ITEMS REQUESTED

ELDERLY WAIVER SERVICES

☐ Denial
☐ Termination
☐ Reduction

Reason Code: ____________________

DTR Comments *(e.g. inpatient admission/out of country date/services reduced via CL Tool)* ____________________

Service Description ____________________ *select an option*

Frequency *(e.g. hrs per week/daily/monthly)* ____________________ Rate Per Unit *if negotiated* ____________________

Provider Name ____________________ NPI ____________________

Provider Phone ____________________ Fax ____________________

Elderly Waiver DTR Notification (continued)

NEW OR CURRENT EW DATE SPAN ________________________ **TO** ________________________

SERVICES/PROCEDURES/ ITEMS REQUESTED

ELDERLY WAIVER SERVICES

☐ Denial
☐ Termination
☐ Reduction

Reason Code: ____________

DTR Comments *(e.g. inpatient admission/out of country date/services reduced via CL Tool)* ____

Service Description ____ *select an option*

Frequency *(e.g. hrs per week/daily/monthly)* ____________________ Rate Per Unit *if negotiated* ________________________________

Provider Name ________________________________ NPI ________________________

Provider Phone ________________________________ Fax ________________________

SERVICES/PROCEDURES/ ITEMS REQUESTED

ELDERLY WAIVER SERVICES

☐ Denial
☐ Termination
☐ Reduction

Reason Code: ____________

DTR Comments *(e.g. inpatient admission/out of country date/services reduced via CL Tool)* ____

Service Description ____ *select an option*

Frequency *(e.g. hrs per week/daily/monthly)* ____________________ Rate Per Unit *if negotiated* ________________________________

Provider Name ________________________________ NPI ________________________

Provider Phone ________________________________ Fax ________________________

SERVICES/PROCEDURES/ ITEMS REQUESTED

ELDERLY WAIVER SERVICES

☐ Denial
☐ Termination
☐ Reduction

Reason Code: ____________

DTR Comments *(e.g. inpatient admission/out of country date/services reduced via CL Tool)* ____

Service Description ____ *select an option*

Frequency *(e.g. hrs per week/daily/monthly)* ____________________ Rate Per Unit *if negotiated* ________________________________

Provider Name ________________________________ NPI ________________________

Provider Phone ________________________________ Fax ________________________