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 _____

PRIMARY HEALTH CARE PROVIDER

Clinician Name _____

Clinic Name _____ NPI _____

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
☐ Terminating EW Eligibility

Reason Code:

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

Service Description Select 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

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☐ Termination
☐ Reduction
☐ Terminating EW Eligibility

Reason Code: ____________

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

Service Description Select Service Description ____________________ *select an option*

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

Provider Name ____________________ NPI ____________

Provider Phone ____________________ Fax ____________

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