




Waiver Service Approval Form 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.
*Do not use this form for T2029 Specialized Equipment and Supplies. Please refer back to **UCare.org** for appropriate form.*

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

 For questions, **call: 612-676-6705**

 **Email:** CLSintake@ucare.org

MEMBER INFORMATION	Member Name _____ Member ID _____
	Address _____ PMI _____
	City, State, Zip _____ Date of Birth _____
	Phone _____

CC INFO	Care Coordinator Name _____ Phone _____
	Care Coordinator Email _____ Fax _____

Waiver Span Start Date _____ Waiver Span End Date _____
<small>*Please note: services should not be authorized past the end of the waiver span. If a new assessment is performed, all previously authorized services must also be renewed.</small>

SERVICE AGREEMENT	
SERVICE/PROCEDURE/ ITEMS REQUESTED	Service Description _____
	Start Date _____ Frequency _____
	End Date _____ Total Units _____
	Rate Per Unit – if negotiated _____
	Total (\$) Amount Per Date Span – CDCS Only _____
	Provider Name _____ Phone _____
	EW UMPI/NPI* _____ Fax _____
	*To ensure accurate claims payment, please verify with the provider the billing UMPI/NPI for EW services.
	Agency Email Address _____
	Please provide an explanation of your request. (If adjusting authorization due to case mix change, DTR is required. For all other changes to existing authorizations, specific details required.)

Waiver Service Approval Form (continued)

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Notes: T2029 – Supplies/Equipment: Please refer to EOC.
This approval form does not guarantee payment; benefits are subject to eligibility at the time service is being rendered.

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