Reset Form

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.

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

Email: **CLSintake@ucare.org**

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

MEMBER INFORMATION

Member Name _____ Member ID _____

Address _____ PMI _____

City, State, Zip _____ Date of Birth _____

Phone _____ Gender: ☐ Female ☐ Male

CC INFO

Care Coordinator Name _____ Phone _____

Care Coordinator Email _____ Fax _____

Waiver Span Start Date _____ Waiver Span End Date _____

*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.

SERVICE/PROCEDURE/ ITEMS REQUESTED

SERVICE AGREEMENT

Service Description Select a service _____

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)

SERVICE/PROCEDURE/ ITEMS REQUESTED

SERVICE AGREEMENT

Service Description Select a service

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.)

SERVICE/PROCEDURE/ ITEMS REQUESTED

SERVICE AGREEMENT

Service Description Select a service

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.)

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.