



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**



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 _____ Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male

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

SERVICE/PROCEDURE/ITEMS REQUESTED	SERVICE AGREEMENT
	Service Description _____
	Start Date _____ Frequency _____
	End Date _____ Total Units _____
	Rate Per Unit – if negotiated _____
	Total (\$) Amount Per Date Span – CDCS Only _____
	Provider Name _____ NPI _____
	Provider Phone _____ Fax _____
	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 AGREEMENT
SERVICE/PROCEDURE/ ITEMS REQUESTED	<p>Service Description _____</p> <p>Start Date _____ Frequency _____</p> <p>End Date _____ Total Units _____</p> <p>Rate Per Unit – if negotiated _____</p> <p>Total (\$) Amount Per Date Span – CDCS Only _____</p> <p>Provider Name _____ NPI _____</p> <p>Provider Phone _____ Fax _____</p> <p>Agency Email Address _____</p> <p>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.)</p>

	SERVICE AGREEMENT
SERVICE/PROCEDURE/ ITEMS REQUESTED	<p>Service Description _____</p> <p>Start Date _____ Frequency _____</p> <p>End Date _____ Total Units _____</p> <p>Rate Per Unit – if negotiated _____</p> <p>Total (\$) Amount Per Date Span – CDCS Only _____</p> <p>Provider Name _____ NPI _____</p> <p>Provider Phone _____ Fax _____</p> <p>Agency Email Address _____</p> <p>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.)</p>

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.