

# Supplemental Benefits

## Denial, Termination or Reduction Notification

### Care Coordinator Use Only

Form to be submitted within one business day of determination  
Incomplete, illegible, or inaccurate forms will be returned to the sender.



**Fax** form to: 612-884-2185  
or 1-866-402-5018



E-Mail: [CLSIntake@ucare.org](mailto:CLSIntake@ucare.org)

Member Information	
Name:	Date of Birth:
Member ID:	Product:
Care Coordinator/Case Manager Information	
Name:	Delegate:
Phone:	Fax:
Email:	
Denial, Termination, Reduction Information	
Service Description:	Provider:
Frequency:	Provider NPI/UMPI (as applicable)
Comments (e.g., date of nursing home admission or other reason for DTR):	
Additional Denial Information	
Service Description:	Provider:
Frequency:	Provider NPI/UMPI (as applicable)
Comments (e.g., date of nursing home admission or other reason for DTR):	
Additional Denial Information	
Service Description:	Provider:
Frequency:	Provider NPI/UMPI (as applicable)
Comments (e.g., date of nursing home admission or other reason for DTR):	