Clear Form

ELDERLY WAIVER DTR NOTIFICATION
Care Coordinator Use Only

Incomplete, illegible, or inaccurate forms will be returned to sender. Please complete the entire form. Please allow up to 14 calendar days for processing of this request. If this is a reduction of service, no additional Waiver Service Approval Form submission is required. For a change in provider, please use the WSAF.

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

E-Mail: CLSIntake@ucare.org

For questions, **call: 612-676-6705**
(To reach a representative, dial option 2 then option 4)

MEMBER INFORMATION:	
Name:	Date of Birth:
Address	Phone:
Member ID:	PMI:

CARE COORDINATOR INFORMATION:	
Care Coordinator Name:	
Phone:	Fax:
Email:	

NEW OR CURRENT WAIVER SPAN:	
Start Date:	End Date:

SERVICE/ITEM REQUESTED:	
☐Denial ☐Termination ☐Reduction ☐Terminating EW Eligibility	Reason code: *Required: select code
Service Description: Select a service	
Frequency:	Rate per unit (*if negotiated*):
Provider:	
EW UMPI or NPI:	
Phone:	Fax:
DTR Comments *(e.g., date of Nursing Home admission/out of country date/services reduced via CL Tool*):	

SERVICE/ITEM REQUESTED:	
☐Denial ☐Termination ☐Reduction ☐Terminating EW Eligibility	Reason code: *Required: select code
Service Description: Select a service	
Frequency:	Rate per unit (*if negotiated*):
Provider:	
EW UMPI or NPI:	
Phone:	Fax:
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Provider:	
EW UMPI or NPI:	
Phone:	Fax:
DTR Comments *(e.g., date of Nursing Home admission/out of country date/services reduced via CL Tool*):	