

Waiver Service Approval Form Care Coordinator Use Only

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: For questions, **call: 612-676-6705** (Option 2, then Option 5) Member Name ______ Member ID _____ **FORMATION** Address _____ PMI _____ City, State, Zip Date of Birth Phone ____ Care Coordinator Name ______ Phone ______ Phone _____ Care Coordinator Email _____ Fax _____ 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 AGREEMENT Service Description _____ Start Date _____ Frequency _____ End Date _____ Total Units _____ SERVICE/PROCEDURE/ Rate Per Unit – if negotiated _____ **ITEMS REQUESTED** Total (\$) Amount Per Date Span – CDCS Only

 * To ensure accurate claims payment, please verify with the provider their email address and billing UMPI or NPI for EW services.

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.)

Provider Name ______ Phone _____

Provider Email Address* _____ Fax _____ Fax _____

EW UMPI or NPI*

Waiver Service Approval Form (continued)

	SERVICE AGREEMENT		
	Service Description		
SERVICE/PROCEDURE/ ITEMS REQUESTED	Start Date	Frequency	
		Total Units	
	Rate Per Unit – if negotiated		
	Total (\$) Amount Per Date Span - CDCS Only		
		Phone	
		Fax	
ERVICI	EW UMPI or NPI*		
SER	*To ensure accurate claims payment, please verify wi	th the provider their email address and billing UMPI or	
		If adjusting authorization due to case mix change,	
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SERVICE/PROCEDURE/ ITEMS REQUESTED	Service Description Start Date End Date Rate Per Unit – if negotiated Total (\$) Amount Per Date Span – CDCS Only Provider Name Provider Email Address*	Frequency Total Units Phone Fax	
	Service Description Start Date End Date Rate Per Unit – if negotiated Total (\$) Amount Per Date Span – CDCS Only Provider Name Provider Email Address* EW UMPI or NPI*	Frequency Total Units Phone Fax	
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Notes: This approval form does not guarantee payment; benefits are subject to eligibility at the time service is being rendered.

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SERVICE/PROCEDURE/ ITEMS REQUESTED		Frequency	
	End Date	Total Units	
	Rate Per Unit – if negotiated		
	Total (\$) Amount Per Date Span – CDCS Only		
	Provider Name	Phone	
	Provider Email Address*	Fax	
ERVICI	EW UMPI or NPI*		
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