

**Member Information** 

Name:

Member ID:

## Waiver Service Approval Form

Date of birth:

PMI:

Incomplete, illegible, or inaccurate forms will be returned to sender. All applicable information must be included for timely processing of the request. Allow up to 14 calendar days for processing of this request. Do not use this form for Specialized Equipment and Supplies (T2029). **Form must be completed by UCare Care Coordinator.** 

Submit form	and	relevant	docum	entation	via:
Jubilli lolli	ullu	I CIC VALIE	accarri	Cilcation	viu.

Fax: 612-884-2185

Email: CLSIntake@ucare.org

For questions, call: 612-676-6705

To reach a representative, choose option 2, then option 5

Address:		City/State/Zip:				
Additional Information						
EW Date span: to	)		Number of EW services authorized:			
MnCHOICES Assessment date: Case		Mix:	Annual Budget:			
Care Coordinator Information						
Care Coordinator name:						
Phone:			Fax:			
Email:						
Service Agreement						
Service Description:						
Provider Name:			Email Address*:			
EW NPI or UMPI*:	or UMPI*: Phone number		r:	Fax number:		
Start date:		End date:				
-requency: per			Total units per au	ıth span:		
Rate per unit (if negotiated):						
CDCS approved amount (if application application)				CDCS Enhanced Rate:	Yes	
Provide an explanation for the autho required. *To ensure accurate claims <sub>I</sub> NPI for EW services.	orization. <b>**</b> A payment, pled	II othe	er changes to existii ify with the provider	ng authorizations, specific de their email address and billing	tails g UMPI or	
**If decreasing amount of services, a	a DTR is requ	ired.				

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Manabay Infamatian					
Member Information		M   10			
Name:		Member ID:			
Service Agreement					
Service Description:					
	Provider Name:		Email Address*:		
EW NPI or UMPI*:	Phone number:	Fax number:			
Start date:	tart date:		End date:		
Frequency: per	requency: per		Total units per auth span:		
Rate per unit (if negotiated):					
Provide an explanation for the author					
required. *To ensure accurate claims	payment, please verij	fy with the provider	their email address and billing UMPI		
or NPI for EW services.					
**If decreasing amount of services,	a DTR is required.				
Service Agreement					
Service Description:					
Provider Name:		Email Address*:			
EW NPI or UMPI*:	Phone number:		Fax number:		
Start date:		End date:			
- requency: per		Total units per auth span:			
Rate per unit (if negotiated):		•			
Provide an explanation for the authorization. **All other changes to existing authorizations, specific details					
required. *To ensure accurate claims	payment, please verij	fy with the provider	their email address and billing UMPI		
or NPI for EW services.					

\*\*If decreasing amount of services, a DTR is required.

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Service Agreement					
Service Description:					
Provider Name:		Email Address*:			
EW NPI or UMPI*:	Phone number:		Fax number:		
Start date:		End date:			
Frequency: per		Total units per auth span:			
Rate per unit (if negotiated):					
Provide an explanation for the authorization. **All other changes to existing authorizations, specific details required. *To ensure accurate claims payment, please verify with the provider their email address and billing UMPI or NPI for EW services.					

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