



Targeted Case Management Approval Form (Updated 12/10/2010)

Fax this form to BHP at 763-486-4437 or MMSI (if a Mayo primary care clinic) at 1-888-889-7822

GENERAL INFORMATION: Facility/Agency providing the assessment, or services:

UCare Member name: _____ UCare or PMI number: _____
 Facility/Agency Name: _____ NPI number: _____
 Case Manager: _____
 Fax number: _____ Phone Number: _____

NEW MEMBER SERVICE NOTIFICATION *(please fill in all information requested)*

Initial/Requested start date: _____ Requested span (up to 6 months): _____
 Axis I diagnosis: _____ Next review date: _____
 Provider name and Agency who completed the Functional Assessment:
 _____ Date: _____
 Provider name and Agency who completed the Diagnostic Assessment:
 _____ Date: _____

REQUEST TO CONTINUE SERVICES: INITIAL 6 MONTH REVIEW

If this is a request for the initial 6 month review following initiation of services, please submit the most recent Diagnostic Assessment, Functional Assessment, and an updated Individual Community Support Plan (ICSP) or Individual Family Community Support Plan (IFCSP).

REQUEST TO CONTINUE SERVICES: CONTINUING 6 MONTH REVIEW

For every 6 months after the initial 6 month review, please submit the most recent updated ICSP or IFCSP and answer the following questions:

What is the member's progress or lack of progress towards goals? _____

What are the barriers for this member achieving goals? _____

Has the plan of care been modified and, if so, how? _____

Services the member is receiving: _____

Frequency and type of contact (i.e. phone, face to face): _____

Requested start date: _____ Requested time span (up to 6 months): _____

NOTE: UCare's designated Utilization Review entity may request additional information as needed.