



# Targeted Case Management Form

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 providing the assessment, services, or denial:**

UCare Member name: \_\_\_\_\_ UCare or PMI number: \_\_\_\_\_

Facility 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.**

**DENIAL OF SERVICES**

Please submit the Diagnostic Assessment, Functional Assessment, ICSP, or IFCSP and any other documentation.

Reason for denial: \_\_\_\_\_