



WAIVER SERVICE APPROVAL FORM

Incomplete or illegible forms will be returned to sender. Please complete the entire form. All information is required in order for UCare to process the Waiver Service Approval form.

Today's Date: _____

1. MEMBER INFORMATION			
First Name:	_____	Member's UCare ID:	_____
Last Name:	_____	PMI:	_____
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB:	_____
Diagnosis:	_____	ICD-9 Code:	_____

2. CASE MANAGER INFORMATION	
CM Name:	_____
Care System:	_____
Phone Number:	_____
Fax:	_____

3. PROVIDER INFORMATION and SERVICE AGREEMENT			
Provider Name:	_____		
Provider UCare ID #:	_____	Provider NPI ID#:	_____
Provider Phone:	_____	Provider Fax:	_____

Line Item 1					
Procedure Code/Modifier	Service Description				Location Code
_____	_____				_____
Start Date	End Date	Rate per Unit	Frequency	Total Units	Total Amount
_____	_____	\$ _____	_____	_____	\$ _____
Narrative of Service Code Approved					

Line Item 2					
Procedure Code/Modifier	Service Description				Location Code
_____	_____				_____
Start Date	End Date	Rate per Unit	Frequency	Total Units	Total Amount
_____	_____	\$ _____	_____	_____	\$ _____
Narrative of Service Code Approved					

Line Item 3					
Procedure Code/Modifier	Service Description				Location Code
_____	_____				_____
Start Date	End Date	Rate per Unit	Frequency	Total Units	Total Amount
_____	_____	\$ _____	_____	_____	\$ _____
Narrative of Service Code Approved					

Note to Provider of Care: This approval form does not guarantee payment, benefits are subject to eligibility at the time service is being rendered.

PLEASE FAX OR MAIL COMPLETED FORMS TO:

Fax Line: 612-884-2185

Mailing: UCare Clinical Services - P.O. Box 52 Minneapolis, Minnesota 55440-0052

INSTRUCTIONS

- Fill in all sections of the request form. Incomplete or illegible forms will be returned to sender. All information is required in order for UCare to process the Waiver Service Approval form.
- If member is receiving services through multiple providers, please use separate waiver approval forms for each provider. If more than 3 services are being rendered by one provider, use additional forms as necessary.
- Fax or mail completed forms to:

Fax: 612-884-2185

**US Mail: UCare Clinical Services
P.O. Box 52, Minneapolis, MN 55440-0052**

Line Item Field Description

The diagram shows a form with the following fields and callout boxes:

- Procedure Code** (including any necessary modifiers): Callout box: "Procedure Code including any necessary modifiers."
- Service Description** (e.g. 24hr Customized Living): Callout box: "Service Description (e.g. 24hr Customized Living)"
- Frequency**: Callout box: "Frequency Specify the frequency (e.g. Monthly, Weekly, Daily, Hourly) The frequency specified in this field should match the 'rate per unit' (e.g. rate per unit is approved for monthly, the frequency field should be specified as monthly.)"
- Location Code**: Callout box: "Location Code This is where the service takes place."
- Start Date** (MM/DD/YYYY): Callout box: "Start Date MM/DD/YYYY"
- End Date** (MM/DD/YYYY): Callout box: "End Date MM/DD/YYYY"
- Rate per Unit**: Callout box: "Rate per Unit Specify a dollar amount for rate per unit, including any negotiated rate."
- Total Units**: Callout box: "Total Units Specify the total units being approved between the specified dates of services."
- Total Amount**: Callout box: "Total Amount Populate the total dollar amount."
- Narrative of Service Code Approved**: Callout box: "Narrative of Service Code Approved As necessary, include short narrative of service code approved. For transportation, indicate 'one way trip' or 'round trip' including mileage."

The form fields are: Procedure Code/Modifier, Service Description, Location Code, Start Date, End Date, Rate per Unit, Frequency, Total Units, Total Amount, and Narrative of Service Code Approved.