

CONSUMER NAME (As appears on Medicaid Card): _____ RECORD NO: _____

DOB: _____ Age: _____ Gender: Male Female

Complete all blanks and forward to Utilization Management **PRIOR** to any terminations/discharges

Funding Source(s): Health Choice Medicaid Medicare Private Insurance State Funds Self-pay
Medicaid ID# _____ Insurance Company _____ Policy #: _____

DATE: _____ DATE OF INITIAL CONTACT: _____ DATE OF LAST CONTACT: _____

Consumer's Address: _____ Legally Responsible Person: _____

(Type of Relationship) _____

Address: _____

SERVICE(S) TO BE TERMINATED: _____

REASON(S) FOR TERMINATION: _____

COURSE OF TREATMENT/HABILITATION: (Include Service(s) consumer currently receiving and service(s) will continue to receive following termination): _____

CONSUMER'S CURRENT STATUS: (Stable, unstable, inpatient, detox, jail, involuntary commitment, etc) _____

CURRENT DIAGNOSIS (Complete all that apply): (Axis I-V; Code and Diagnosis)

AXIS I _____
AXIS II _____
AXIS III _____
AXIS IV _____
AXIS V _____

Medication	Dosage & Route	Schedule	Active Prescription

CLINICIAN SIGNATURE/DATE

SUPERVISOR'S SIGNATURE/DATE

PSYCHIATRIST/DATE

PROVIDER AGENCY

PROVIDER ADDRESS/LOCATION

DATE REVIEWED: _____

RECOMMENDATION AND REASON: _____

UTILIZATION MANAGEMENT STAFF/DATE

MEDICAL DIRECTOR SIGNATURE/DATE