APPENDIX W

SOURCE (MIF)

ATTN:_____

__Provider to Case Manager __Case Manager to Provider

__Initial __Change __ Discharge __FYI Response required? __Yes __ No

Provider Name _____

Member Name _____ Medicaid No. _____

Service type: __ADH __ ALS __ERS __ HDM __HDS __PSS __EPS

Initial

Service offered? ___ No-Reason _____

___ Yes-Date services initiated_____

___ Frequency/Units_____

Change/FYI

__Recommendation for change in service __Change in frequency/units by case manager

__Change in mbr's. Health/functional status __Change of physician/CM

__Hospitalization __Service not delivered __Other

FYI

Explanation:_____

_____

_____Effective date of change:_____

Discharge

Discharge Reason: _____

_____

Date of Discharge: _____

Comments_____

_____

Signature_____ Date _____

Title _____ Phone _____

Signature _____ Date _____

Title _____ Phone _____

CM Email: _____