Provider Request for Discharge/Assistance with Inappropriate Behavior

Section 1 - What would you like Partnership to do?

- ☐ Would you like Partnership's Care Coordination Team to reach out to the member to counsel them on improving their behavior?
- ☐ Do you want to request that the member be disenrolled from your office(s)? **Must attached required documentation**.

Section 2 - Member Information: Partnership ID (CIN) #_____

Name: _____ DOB: _____ Phone #_____

Section 3 - Member Care Information:

1. Is the member in treatment for an active medical condition? ☐ No ☐ Yes - attach description of medical condition
2. Are there any diagnostic testing or surgeries scheduled? ☐ No ☐ Yes - attach list of scheduled procedures and any active TARs and/or RAFs. Please include TAR & RAF #s:

   _____

Section 4 - Provider Submitting Request:

1. PCP/Med Grp Name: _____ PCP/Group's Partnership PCP#: _____
   Does discharge apply to all facilities and/or locations affiliated with the group? ☐ Yes ☐ No
   If yes, list all the Partnership providers or locations that apply:

2. Have you already communicated with the member regarding your concerns? ☐ Yes ☐ No ☐ N/A If yes, what did you advise the member:

   _____

3. Who do we contact if we have questions regarding the member's care or the reason for disenrollment:

   Print Name: _____ Phone # _____

4. Who and where do we fax our decision to:

   Print Name: _____ Phone # _____ Fax#: _____

Section 5 - Reason for your request:

Please check all applicable boxes. **If you are requesting to disenroll the patient, attach documentation outlined in the policy**. If the action of the member is not specified in the policy, provide documentation outlining the incident or reason for request.

☐ Missed appointments ☐ Disruptive/verbally inappropriate behavior ☐ Suspected fraud
☐ Failure to obtain/maintain a collaborative relationship ☐ Non-Compliance/refusal to follow treatment plan.*
☐ Inappropriate sexual comments or advances
☐ Threats of violence and/or violent behavior; has behavior been reported to police? ☐ Yes ☐ No If "No" please explain why:

_____

☐ Other: _____

Note: *All requests for discharge for non-compliance are reviewed by a Partnership Medical Director. Presence of a Substance Abuse Disorder alone is not sufficient grounds for discharge. Please refer to specialty care or address treatment as necessary.*

Signature of Provider: _____ Date: _____

Print name of Provider: _____

Section 6 - Fax to (707) 420-7580 attention **Enrollment Unit:**
Partnership has ten (10) business days to process your request from the date received. Forms that are incomplete or missing required documentation may be denied.

********************************PARTNERSHIP INTERNAL USE***********************************

Member #: _____

DECISION:

☐ Pended Sent to Dept./Name: _____ Date sent: _____ Due back by: _____

☐ Approved Effective: _____ New Assignment: _____ Date approved:

☐ Request Denied Reason: _____ Date denied: _____

Referral to Case Management: ☐ Yes; date: _____ ☐ No

Letter #_____; Date notice sent to provider: _____

Letter #_____; Date notice sent to member: _____

☐ Call Center/Amisys entries completed on date: _____

COMMENTS:

MS _____

CC _____

PR _____

Member Services Director Signature: _____ Date: _____