



Provider Request for Discharge/Assistance with Inappropriate Behavior

Section 1 - What would you like Partnership to do?

- Would you like Partnership 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:

- Is the member in treatment for an active medical condition?
Are there any diagnostic testing or surgeries scheduled? Please include TAR & RAF #s:

Section 4 - Provider Submitting Request:

- PCP/Med Grp Name: PCP/Group's Partnership PCP#:
Does discharge apply to all facilities and/or locations affiliated with the group?
Have you already communicated with the member regarding your concerns?
Who do we contact if we have questions regarding the member's care or the reason for disenrollment:
Who and where do we fax our decision to:

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?
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 Partnership's Enrollment Unit:**

Partnership has ten (10) business days to process your request from the date received. Forms that are incomplete or missing the 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: \_\_\_\_\_