



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:

- Is the member in treatment for an active medical condition?
Are there any diagnostic testing or surgeries scheduled? and/or RAFs. 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?
If yes, list all the Partnership providers or locations that apply:
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:
Print Name: Phone #
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?
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: _____