PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Provider Request for Discharge/Assistance with Inappropriate Behavior

Section 1 - What would you like PHC to do?

- ☐ Would you like PHC'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: PHC 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 PHC PCP#: _____
   Does discharge apply to all facilities and/or locations affiliated with the group? ☐ Yes ☐ No
   If yes, list all the PHC 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 PHC 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 PHC Member Services' Enrollment Unit:

- Lake, Marin, Mendocino, Napa, Solano, Sonoma and Yolo members fax request to (707) 420-7580.
- Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou and Trinity members fax request to (530) 223-2508.

PHC has ten (10) business days to process your request once it has been received.

Please be advised, if the form is incomplete or missing required information, your request will be denied.

****************************PHC 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: _____