

# Provider Initiated Notice - Adverse Action

(Please Print All Information)

Provider Name: \_\_\_\_\_ Date of Request: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_, City \_\_\_\_\_, TN Zip Code: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Contact Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Ext \_\_\_\_

Attending Physician/Treating Practitioner - Name/Credential: \_\_\_\_\_, \_\_\_\_\_

Enrollee Name: \_\_\_\_\_ MCO/BHO:  Premier  TBH  TBH-East

VSHP/VO  AmeriChoice  AmeriGroup

SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ CRG/TPG: \_\_\_\_  N/A

Address: \_\_\_\_\_, City \_\_\_\_\_, TN Zip Code: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Admission Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ OR Referral Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Discharging Level of Care:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Inpatient psych/dual  | <input type="checkbox"/> Supervised Residential | <input type="checkbox"/> CTT <input type="checkbox"/> CCFT <input type="checkbox"/> PACT |
| <input type="checkbox"/> Inpatient Detox       | <input type="checkbox"/> PHP/Psych              | <input type="checkbox"/> Case Management   |
| <input type="checkbox"/> Inpatient Rehab       | <input type="checkbox"/> PHP/A&D                | <input type="checkbox"/> Medication Management   |
| <input type="checkbox"/> Subacute              | <input type="checkbox"/> IOP/A&D                | <input type="checkbox"/> Outpatient Therapy  |
| <input type="checkbox"/> Residential Treatment | <input type="checkbox"/> IOP/Psych              | <input type="checkbox"/> Other Outpatient: _____   |

Date of Anticipated Adverse Action: \_\_\_\_/\_\_\_\_/\_\_\_\_

Request For<sup>1</sup>  Delay  Suspension  Reduction  Discharge/Termination

AMA (● **STOP HERE**. No further information is needed. Go to last [staff name/signature] field.)

Transfer - Same LOC: Provider Name \_\_\_\_\_ For LOC Type: \_\_\_\_\_  
(●)

If **Delay or Suspension**, service will be available (mm/dd/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_:\_\_\_\_  
 am  pm

Explain action being taken to remedy access problem: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If **Reduction**, state how often will the consumer be seen: \_\_\_\_\_

<sup>1</sup> For **inpatient** levels of care, this form must be submitted one (1) business day prior to the proposed adverse action notice date (notice will then give member two (2) days before actual adverse action occurs).

For **outpatient** levels of care, this form must be submitted eight (8) calendar days prior to the proposed adverse action notice date (notice will then give member ten (10) days before actual adverse action occurs).

For **ANY Adverse Action**, provide reasons for the proposed action—*based on specific facts that are personal to the Enrollee*—as to why the Enrollee no longer meets medical necessity criteria:

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**AND**, list the specific clinical documentation used to support your decision (include dates of service):

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**DRAFT discharge summary attached**    – or –     **Discharge plan as follows:**

**Recommended Level of Care:**

- |   |                                    |  |                               |                               |
|---|------------------------------------|--|-------------------------------|-------------------------------|
| <input type="checkbox"/> Inpt Rehab                       | <input type="checkbox"/> PHP/Psych | <input type="checkbox"/> CTT                   | <input type="checkbox"/> CCFT | <input type="checkbox"/> PACT |
| <input type="checkbox"/> Subacute                         | <input type="checkbox"/> PHP/A&D   | <input type="checkbox"/> Case Management       |                               |                               |
| <input type="checkbox"/> Residential/Psych                | <input type="checkbox"/> IOP/A&D   | <input type="checkbox"/> Medication Management |                               |                               |
| <input type="checkbox"/> Supervised Treatment             | <input type="checkbox"/> IOP/Psych | <input type="checkbox"/> Outpatient Therapy    |                               |                               |
| <input type="checkbox"/> Other Outpatient, specify: _____ |                                    |  |                               |                               |

Discharge to Jail ( ● **STOP HERE.** Go to last [staff name/signature] field.)

**Aftercare Appointments:**

Provider Name / Address / Telephone Number Service Type / Practitioner Name	Appointment Date/Time
Name: _____ T: (_____) _____ - _____ Street: _____ City: _____ ST: _____ Zip Code: _____ Service: _____ Practitioner: _____	____ / ____ / ____ ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm
Name: _____ T: (_____) _____ - _____ Street: _____ City: _____ ST: _____ Zip Code: _____ Service: _____ Practitioner: _____	____ / ____ / ____ ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm
Name: _____ T: (_____) _____ - _____ Street: _____ City: _____ ST: _____ Zip Code: _____ Service: _____ Practitioner: _____	____ / ____ / ____ ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm
Name: _____ T: (_____) _____ - _____ Street: _____ City: _____ ST: _____ Zip Code: _____ Service: _____ Practitioner: _____	____ / ____ / ____ ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm

Name: _____ T: (_____) _____ - _____	____ / ____ / ____
Street: _____ City: _____ ST: _____ Zip Code: _____	____:____ <input type="checkbox"/> am
Service: _____ Practitioner: _____	<input type="checkbox"/> pm

Effective date of discharge plan: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

The information above is correct to the best of my knowledge. I give my permission for the MCO/BHO to notify the member of this information on my behalf.

Staff Name/Credential (printed): \_\_\_\_\_ Title: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Please fax this form to the appropriate MCO/BHO at:**

**Magellan(TBH, TBH-East, and Premier)1-800-325-7868**

**AmeriChoice 1-888-785-1434**

**AmeriGroup 1-866-920-6006**

**VSHP / Value Options**

**East: 1-800-859-2922**

**West: 1-866-320-3800**