Provider Initiated Notice - Adverse Action

Electronic Form

Provider Name: Date of Request (mm/dd/yy): *

(* - Click on drop-down box)

Address: City , TN Zip Code:

Telephone: ( ) Provider Grier Fax: ( )

Contact Name: Telephone: ( ) Ext.

Attending Physician/Treating Practitioner - Name/Credential:

Enrollee Name: **MCO/BHO**: * CRG/TPG: ☐ N/A

SSN: Enrollee DOB (mm/dd/yy): *

Street Address: , * # , City , State Zip Code:

Telephone: ( )

Admission Date (mm/dd/yy): * _ - **OR** - **Referral Date**:*

Discharging Level of Care:

☐ Inpatient psych/dual	☐ Supervised Residential	☐ CTT ☐ CCFT ☐ PACT
☐ Inpatient Detox	☐ PHP/Psych	☐ Case Management
☐ Inpatient Rehab	☐ PHP/A&D	☐ Medication Management
☐ Subacute	☐ IOP/Psych	☐ Outpatient Therapy
☐ Residential Treatment	☐ IOP/A&D	☐ Other Outpatient:

Date of Anticipated Adverse Action(mm/dd/yy): *

Request For[1] ☐ Delay ☐ Suspension ☐ Reduction ☐ Discharge/Termination

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

☐ Transfer to same LOC: Facility Name for * (● **STOP HERE)**

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

Explain action being taken to remedy access problem:

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

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:

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

☐ **DRAFT discharge summary attached – OR** ☐ **Discharge plan as follows:**

Recommended Level of Care:

☐ Inpt Rehab ☐ PHP/Psych ☐ CTT ☐ CCFT ☐ PACT

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[1] A written notice shall be given to an enrollee of any provider-initiated reduction, termination or suspension of: Any behavioral health service for a priority enrollee; any inpatient psychiatric 24 hour or residential service; Any service being provided to treat a patient's chronic condition across a continuum of services when the next appropriate level of medical service is not immediately available. When required, written notice must be provided to an enrollee at least two (2) business days in advance of the proposed action.

- ☐ Sub-acute
- ☐ Residential/Psych
- ☐ Supervised Treatment
- ☐ PHP/A&D
- ☐ IOP/A&D
- ☐ IOP/Psych
- ☐ Case Management
- ☐ Medication Management
- ☐ Outpatient Therapy
- ☐ Other Outpatient, specify:

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

Aftercare Appointments:

Provider/Facility	Service Type Practitioner Name	Appointment Date & Time
Name: Telephone: ( ) Address: City: Zip code:	Service Type: * Practitioner:	* * *
Name: Telephone: ( ) Address: City: Zip code:	Service Type: * Practitioner:	* * *
Name: Telephone: ( ) Address: City: Zip code:	Service Type: * Practitioner:	* * *
Name: Telephone: ( ) Address: City: Zip code:	Service Type: * Other: Specify: Practitioner:	* * *

Effective date of discharge plan(mm/dd/yy): *

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

Staff Name/Credential: , , **Title**: **Date**(mm/dd/yy): *

Please fax this form to the appropriate TennCare plan:

AmeriChoice 1-888-291-2615

AmeriGroup

VSHP
East: 1-800-859-2922
West: 1-866-320-3800
TennCare Select: 1 -800 – 859-2922