MEDICA BEHAVIORAL HEALTH
MH TARGETED CASE MANAGEMENT
NEED FOR DTR NOTIFICATION

Today's Date: _____

AGENCY/COUNTY NAME: _____

CONTACT NAME: _____

CONTACT PHONE NUMBER: _____

MEMBER NAME: _____DOB: _____

MEMBER'S PARENT/GUARDIAN NAME (If Applicable):_____

MEMBER ADDRESS: _____

_____

PHONE #: _____

MEMBER INSURANCE ID# (PMI): _____

Reason Denial Termination Reduction (DTR) notification needed (Mark One):

1) ____ **Ineligible for TCM (determined ineligible from screening)**

2) ____ **Discharge/Termination from TCM when Member does not Agree**

- **Date Member Informed of Decision: _____**
- **Written communication of right to 2nd opinion given to member: ☐Yes ☐No**
- **Does member want a 2nd opinion?: ☐Yes ☐No**
- **Medica Member Appeal Rights document given to member: ☐Yes ☐No**
- **Date MBH Informed of Decision: _____**

MBH Fax Number: 1/855-454-8155 Attention: TCM Team

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