MEDICA®

Denial, Termination, or Reduction (DTR) Form

Date of request:	**Type of request:**

Care Coordinator Information

Care Coordinator (CC):	
Phone:	**Fax:**
Email:	

Member Information

Member name:		
Date of birth:	**Current ID #:**	**Product:**

Primary Care Provider Information

Clinic:	
Provider name:	
Phone:	**Fax:**

Service Information

Action requested:	**Requested by member:**

Item/Service	Units	Servicing provider	Phone	Fax

PCA assessment date:	**Closing Elderly Waiver:**

Rationale Summary for Action

Attach case notes, assessments, or evaluations for supporting documentation.

Fax completed forms to 952-992-3045

Clear Form