

## 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:	Curi	rent ID #:		Product:		
Primary Care Provider Information						
Clinic:						
Provider name:						
Phone:			Fax:			
Service Information						
Action requested: Reques			sted 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

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