# External Delegate Referral Request Form

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| **Care Coordinator (CC):**      **Delegate:**      **CC Supervisor:**       | **Phone Number:**      **Care Coordinator Email:**      **Supervisor Email:**       |
| **Member Name:**      **Member DOB:**       | **Member Medica ID Number:**      **Member Product:**       |
| **Member Primary Care Physician:**       | **Clinic Name/Address:**       |

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| **Personal Care Assistance (PCA) directions****PCA Decrease:*** Did the member choose other services/supports as an alternative to assessed units/hours of the completed PCA Assessment by initialing #2 in section 5 on page 6 of the Supplemental Waiver PCA Assessment and service plan? **Yes** [ ]  **No** [ ]
* **NOTE: If member did not choose reduction to fit within EW budget, CC must begin Denial, Termination, Reduction (DTR) process**

 **PCA Increase:*** Did PCA units increase by 8 or more units per day from previous authorization? **Yes** [ ]  **No** [ ]

* The current PCA assessment **must** accompany referral request.
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**Service Authorization**

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|  **Service description and HCPC code** | **Servicing Provider Name, Address, Phone, Fax, and Tax ID (if known)** | **Units** **(hours/days** **weeks/months)** |  **Cost** | **Service Start Date** | **Service End****Date** |
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***Comments:***

**\*All external delegate referral request forms are to be emailed to:** [**referralrequest@medica.com**](file:///%5C%5CCorp%5CFS%5CCorpShared%5CGOVTPROG%5CCare%20Coordination%20Products%5CCCP%5CCCP%20folders%5CSpecial%20Needs%20Plans%20Admin%5CClinical%20Oversight%20team%5CClinical%20Managers%20MCS%5CPCA%5CPCA%20Assessments%208%2B%20unit%20increase%5Creferralrequest%40medica.com%20)

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